

# South African Medical Journal S.-A. Tydskrif vir Geneeskunde

Organ of the Medical Association of South Africa

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## S.-A. Tydskrif vir Geneeskunde

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### IN THIS ISSUE—IN HIERDIE UITGAWE

Editorial : Van die Redaksie

Problems of Old Age  
Probleme van die Oudag

Original Articles : Oorspronklike Artikels

Gerontology and Geriatrics in Relation to the Problem of Aging  
What can be done for Senescents  
Ovulasie — 'n Nuwe Begrip  
Conical Cornea in Identical Twins

Abstracts : Uittreksels

The Benevolent Fund : Die Liefdadigheidsfonds

Motor Accident Patients in Hospitals

Short Titles for Medical Degrees

New Preparations and Appliances : Nuwe Preparate en Toestelle

Reviews of Books : Boekresensies

Official Announcement : Ampelike Aankondiging

Dr. H. A. Moffat Memorial Fund

In Memoriam (Wilfred Shaw)

Passing Events : In die Verbygaan

Correspondence : Brievenrubriek

Support Your Own Agency Department

(P. xxiii)

Ondersteun u Eie Agentskap-Afdeling

(Bl. xxiii)

Professional Appointments

(Pp. xxiii-xxvi)

Professionele Betrokkings

(Bl. xxiii-xxvi)

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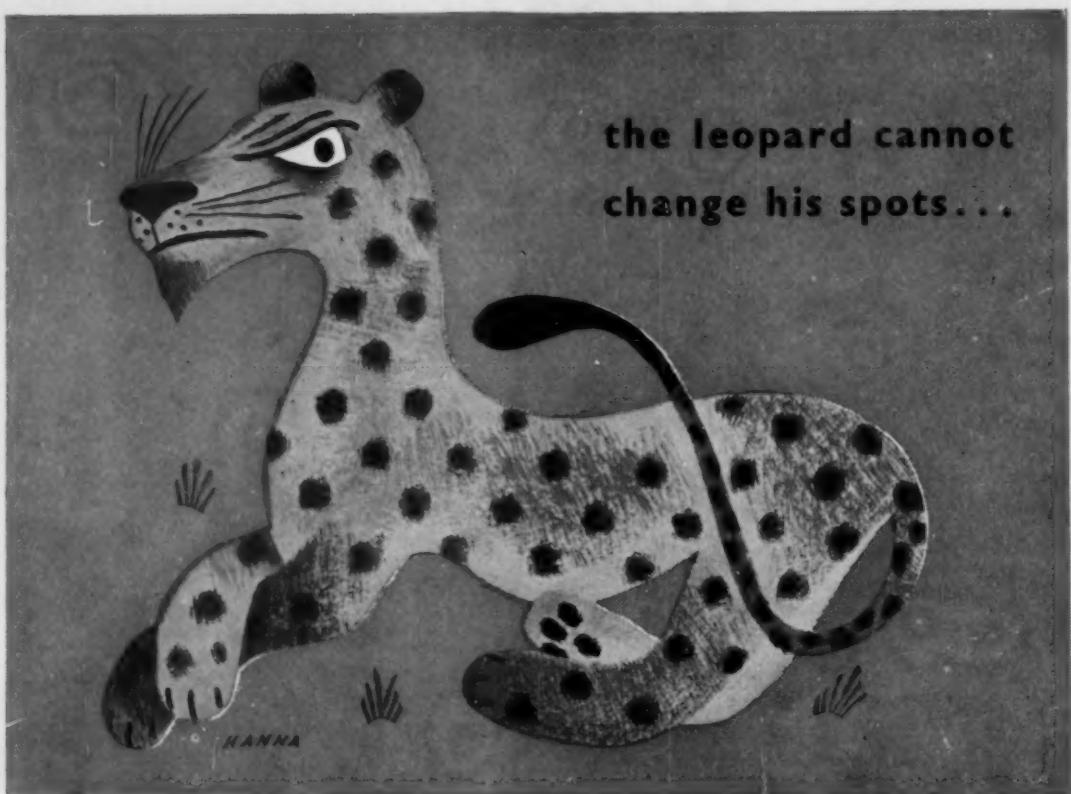
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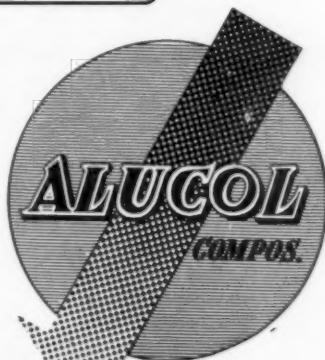
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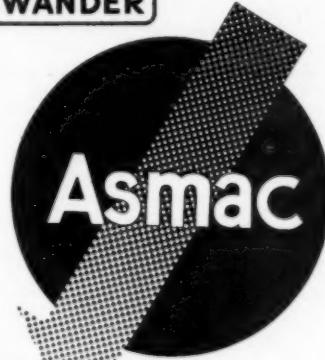
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CONTENTS — INHOUD

Gerontology and Geriatrics in relation to the Problem of Aging. William Ziv, M.D. (Basel), M.D. (Moscow), I.M.S.S.A. ....	141	The Benevolent Fund : Die Liefdadighedsfonds ....	155
Abstracts : Uittreksels ....	142	Dr. H. A. Moffat Memorial Fund ....	156
Editorial : Problems of Old Age ....	143	Motor Accident Patients in Hospitals ....	157
Van die Redaksie : Probleme van die Oudag ....	143	In Memoriam (Wilfred Shaw) ....	157
What can be done for Senescents. I. M. Hurwitz, M.R.C.S., L.R.C.P. ....	145	Short Titles for Medical Degrees ....	158
Ovulasię — 'n Nuwe Begrip. D. A. H. du Toit, M.B., Ch.B., M.D. ....	149	Passing Events : In die verbygaan ....	158
Conical Cornea in Identical Twins. S. Etzine ....	154	New Preparations and Appliances : Nuwe Prepareate en Toestelle ....	159
Official Announcement : Amtelike Aankondiging (Tariff of Fees) ....	155	Reviews of Books : Boekresensies ....	159
		Correspondence : Brieweurbriek ....	160

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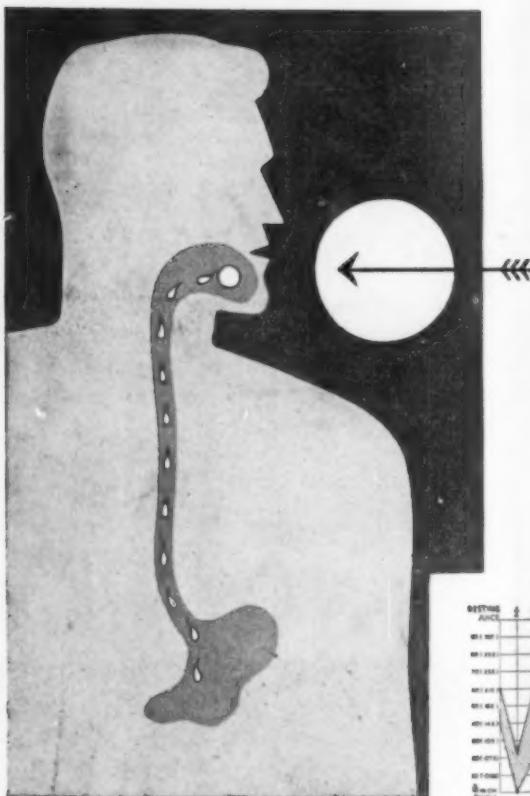
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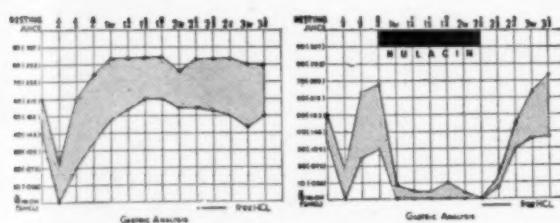


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*British Medical Journal*, 180-182, 26th July, 1952.  
*Medical Press*, 195-199, 27th Feb., 1952.



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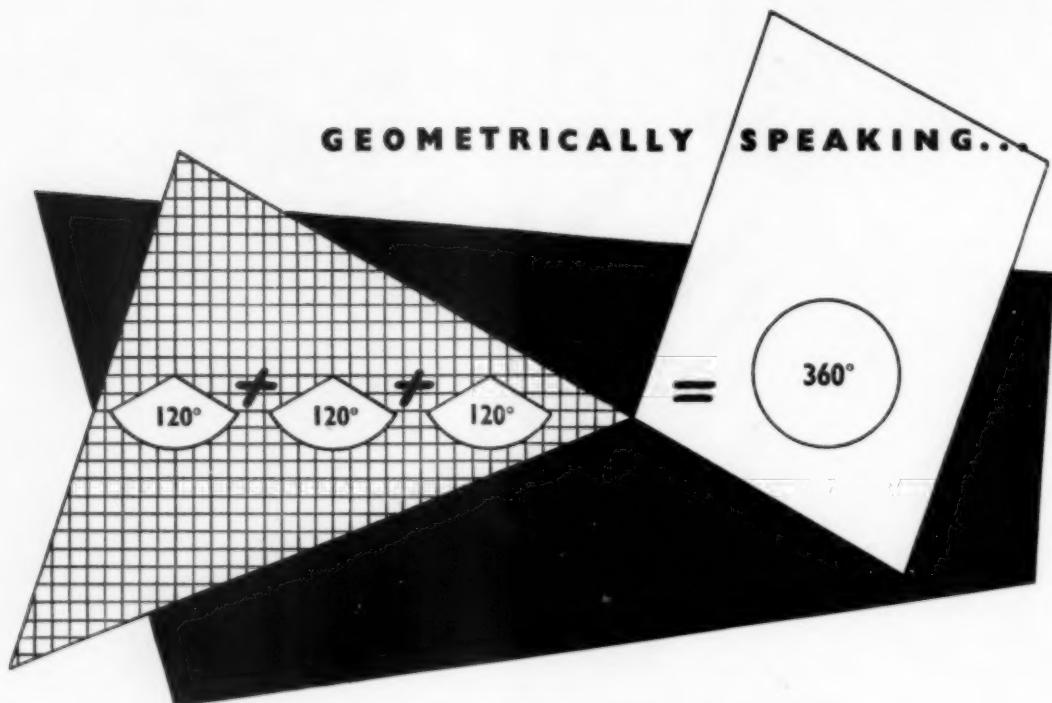
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Ref: Schweinburg and Rutenburg Proc. Soc. Exper. Biol. & Med 1952. Page 482.

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### GERONTOLOGY AND GERIATRICS IN RELATION TO THE PROBLEM OF AGING

WILLIAM ZIV, M.D. (BASEL), M.D. (MOSCOW), L.M.S.S.A.  
*Johannesburg*

'The society which fosters research to save human lives cannot escape responsibility for the life thus extended. It is for science not only to add to the years of life but more important to add life to the years'—Piersol and Bortz.

A hundred years ago, man's span of life was 37 years; 50 years ago it was 47 years, and to-day it has reached the 70-year mark (women 75). This means that to-day 10% of the population is 60 and over.

E. Stieglitz, F. Zeman and others predict that our life-span will soon rise to 100 years, while Prof. Bogomolz states that the average life will (*horribile dictu*) be 125—150 in years to come. He and others maintain that only disease is the cause of death and that old age does not affect the life-span. The increase in longevity is due to improving living conditions, the avoidance of excess heat and cold and of hunger and over-eating (obesity), and improvements in anaesthetics and operations and after-operative care. But the most important are the various antibiotics.

I do not want to stress the fact that Titian and Verdi produced their most famed works at the respective ages of 94 and 84. They are exceptions. The same applies to Bernard Shaw, Einstein and others. But it is interesting that in every country we have leading scientists, statesmen and industrialists of advanced age who are all very ably conducting their departments. Churchill, Malan, Havenga . . . are all over 70. Yet, with their good example, the outdated law which forces the majority of people to retire at the age of 60, and live on a pension which is far from being sufficient to provide for the necessities of life, still persists. The government, the municipality, the social welfare organization and private charity have to step in and help these people. The City of New York, by forcing people to retire, loses about 400 million dollars yearly in production, and spends nearly 600 million dollars on the maintenance of the aged yearly. In England the maintenance of the aged

comes to almost 250 million pounds per annum; nearly as much as the maintenance of medical care throughout England.

Bernard Baruch, after becoming acquainted with the rapid rise of the span of life, expresses himself as follows: 'Neither the atomic energy, nor advances in flying or other transport, can compare with the problem of aging people and its complications.'

Robert Havighurst, a leading sociologist, predicts that there will be so many people of 60 and over in 1980 that they will hold the balance of the voting power in America.

Our institutions, designed for a shorter life-span, are inadequate and outmoded. By and large they do not reflect the advances made in gerontology and geriatrics. We must realize the fact that there are more older people than children in need of services (Harry Levine).

The word *geriatrics*, according to Zeman, was introduced by Dr. Ignaz Nascher in New York City in 1909. It is a branch of medical services devoted to the diagnosis and treatment of diseases of the aged people. Although the word has been in existence for the past 50 years, it was only in the past 5 years that it came into general use. The other new term, *gerontology*, means the scientific study of the aging process in all living matter. Geriatrics is limited to human beings. The student of gerontology also utilizes rats, mice, dogs, elephants or amoebae as they suit his purpose. In other words, geriatrics works at the bedside and gerontology in the research laboratory.

The gerontologist studies the changes in the tissues and in the metabolic rate, cellular atrophy, the elasticity of the skin tissues, the degeneration of the nervous system, impairment of vision, hearing and memory, etc. (Carlson and Stieglitz).

The importance of geriatric medicine is in prevention. The picture of aging is in fact not so depressing as it may appear at first glance, and it is becoming brighter as medical science and practice are learning how to anticipate and prevent many unnecessary sources of

injury. Most of the detriment, most of the depreciation, which occurs in later years is unquestionably due to the cumulative injuries of chronic and progressive disease rather than to aging *per se*.

The research in geriatrics has given evidence indicating that arteriosclerosis may be amenable to preventive procedures. There is great hope that with proper nutritional balance and proper control of metabolic activity much of arteriosclerotic change is open to prevention or at least definite retardation. Preventive geriatric medicine must begin long before old age appears. There is considerable confusion as to the objectives of geriatric medicine, or that part of medical science and practice concerned with the care of the aging and the aged. Many feel that most of the older members of our population are living too long as it is, and that the vastly increasing numbers of the old are becoming a burden on the community. The primary objective of geriatric medicine is not merely to prolong the life-span; it is to modify the abnormalities characteristic of senescence and to control the progressive disorders of later years, thus adding to the health and usefulness of those who are aging.

Preventive geriatrics may be subdivided as follows:

1. Each working man should have a medical check-up once or twice a year to ascertain that he is fit to carry on with his present occupation. He might need glasses or a hearing-aid and if these are given at the first sign of

impairment it would be greatly to his advantage. If a man's work is found to be too strenuous for his state of health, he should, on the doctor's recommendation, be given work which involves less strain and which he will be able to cope with comfortably.

2. People should be encouraged to develop hobbies during their middle years which they will be able to carry into their old age. It is far better to have an interesting hobby of long standing than to force a hobby when old age has already walked in at the door. In many cases it would be easy for a hobby to become a vocation.

3. Physiotherapy, occupational therapy and recreational therapy are very important in the rehabilitation of the aged.

However, the old-age problem is not merely a medical one, but also sociological. Doctors and social workers must work hand in hand and I therefore appeal to Social Science and the Social Welfare Department to give us its full co-operation.

I would like to conclude with emphasis on the importance of having a Geriatric Department and a Gerontology Chair in South Africa. As we have no authorities on these subjects in this country, I suggest that we bring someone from Britain to lecture in Gerontology and to take charge of the Geriatric Department. This has been done in other fields and I see no reason why there should be an objection to following the same procedure in this field, which is becoming more important every day.

#### ABSTRACTS :

Nelson, R. A., Jr. (1953): *The Immune Adherence Phenomenon*. Science, 118, 733.

A reaction between antibody-sensitized microorganisms and erythrocytes, christened the immune-adherence phenomenon, appears to be an essential preliminary step to phagocytosis of the organisms by human leucocytes. This immunologically specific reaction between normal human erythrocytes and microorganisms sensitized with antibody (from the serum of an infected person) requires the presence of a heat-labile substance in normal serum, presumably complement C<sup>1</sup>.

The reaction has been demonstrated *in vitro* with *Treponema pallidum*, *Diplococcus pneumoniae*, *Shigella paradyenteriae*, *Salmonella typhi*, *Micrococcus aureus*, and *Mycobacterium tuberculosis*, and observed on dark-field examination. Antibody-sensitized organisms adhere to the surface of normal human erythrocytes in the presence of C<sup>1</sup>, after which the leucocytes destroy the adherent organisms (leaving the erythrocytes free).

In test runs (with pneumococci) only 4% of the phagocytes in the antibody-free control contained microorganisms after 30 minutes; without erythrocytes, but with antibody and C<sup>1</sup>, 18% of the leucocytes contained pneumococci. In the complete reaction mixture with antibody, C<sup>1</sup>, leucocytes, and erythrocytes, 60% of the leucocytes exhibited phagocytosis at 30 minutes.

However, it is pointed out, that in conditions where large numbers of bacteria are in contact with large numbers of leucocytes, e.g., in abscesses, may involve different mechanisms of phagocytosis.

It is suggested that discovery of the immune-adherence phenomenon may make possible clinical diagnostic procedures using erythrocyte-microorganism preparations for the detection of circulating antibody.

Jefferies, W. McK., et al. (1953): *A Test Distinguishing between Primary Hypothyroidism and Pituitary Insufficiency*. New Engl. J. Med., 249, 876.

Uptake of radioactive <sup>131</sup>I by the thyroid gland under the influence of a single injection of pituitary thyrotropic hormone, affords an accurate method of distinguishing between primary hypothyroidism and pituitary insufficiency. This test consists of oral administration

#### UITTREKSELS

of 10 microcuries of <sup>131</sup>I on two successive days; on the first day the <sup>131</sup>I uptake by the thyroid is determined with a Geiger counter after 3 hours, indicating the control rate. Immediately after this, 4-20 mg. (usually 10 mg.) of thyrotropin are injected. The following day, the second tracer is given and uptake by the thyroid after 3 hours indicates the response to TSH.

In normal subjects the uptake is increased by approximately 10%. In primary hypothyroidism the initial uptake of <sup>131</sup>I is much lower than in normal individuals and TSH fails to increase the low intake appreciably. In hypothyroidism secondary to pituitary insufficiency, however, the low initial uptake of <sup>131</sup>I rises about 10% after the TSH injections (as in normal subjects), indicating insufficiency of endogenous TSH and no pathology of the thyroid itself.

Thyroid hormone administration does not interfere with the test. However, iodine uptake is masked in patients exposed to inorganic iodine (by oral intake or even by skin contact with mild iodine solutions). In such cases, determination of the serum protein-bound iodine levels should be substituted.

The test also revealed a hitherto unrecognized type of thyroid dysfunction, 'low thyroid reserve,' in patients who had lost a considerable amount of thyroid tissue by surgery or previous <sup>131</sup>I treatment or, spontaneously, in early phases of development of hypothyroidism. The remaining thyroid tissue, even if functioning at maximal rate, is incapable of producing enough thyroid hormone to meet the normal physiological requirements and, particularly, the increased needs under stress conditions. Such individuals show a three hours' uptake within normal range, but cannot respond to stimulation with thyrotropin. Low thyroid reserve can hardly be diagnosed by clinical observation or by the customary tests for thyroid dysfunction.

The studies of response to thyrotropin in a case of cretinism with goitre also demonstrated a defect in the ability of the patient's thyroid gland to utilize iodine in the production of thyroxin.

It is pointed out that in addition to obvious clinical application this test also promises to be helpful in the study of thyroid function under various conditions.

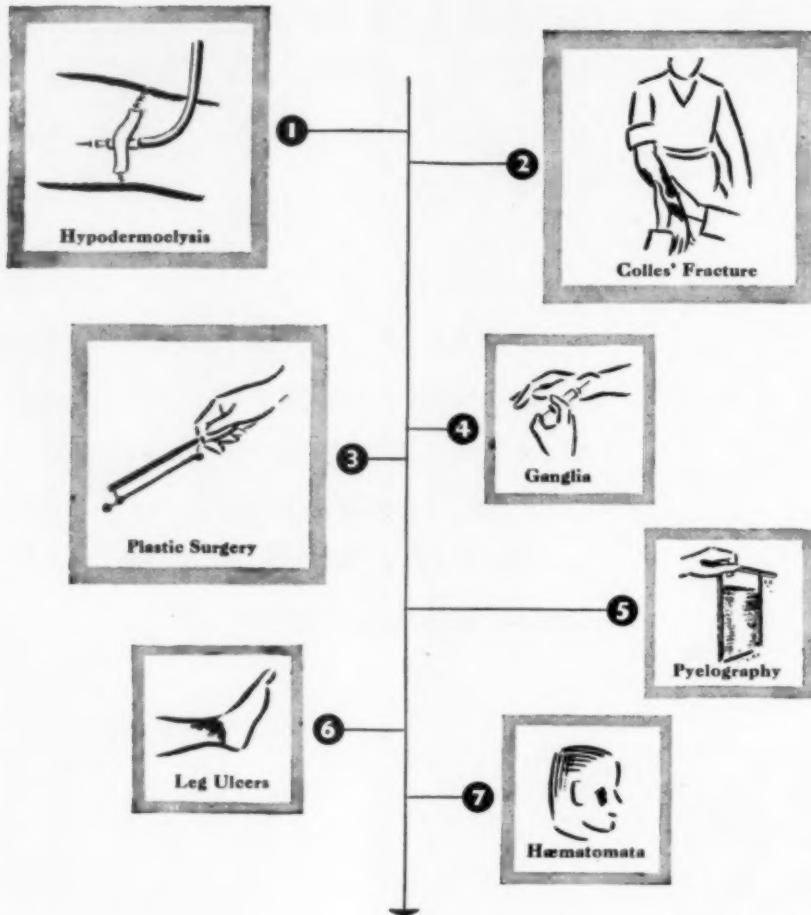
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## South African Medical Journal

### VAN DIE REDAKSIE

### PROBLEME VAN DIE OUDAG

Die gesondheid en welsyn van bejaardes is 'n vraagstuk wat hedendaags baie aandag geniet. Met 'n onafgebroke daling in die sterfesyfer word die verhouding van persone oor 60 jaar tot die res van die bevolking steeds groter en wanneer beide die sterfte- en die geboortesyfer daal, soos dit in die afgelope tyd die geval was, dan is die 'veroudering' van die bevolking selfs meer opvallend.

Indien persone van sestig jaar en ouer ophou werk dan word die wysiging in die ouderdomsamesetting 'n baie groot ekonomiese faktor. Produksie word tot die jeugdiger ouderdomsgroep beperk en die verbruikersbehoefte van die toenemende aantal bejaardes, jongelinge en kinders word 'n steeds swaarder las op die skouers van die produksie-ouderdomsgroep. Die beleid dat gesonde en bekware mense moet aftree louter omdat hul 'n voorgeskrewe ouderdomsgrens bereik het lei klaarblyklik tot 'n toestand van agteruitgang en nie voorspoed nie. Baie sestigjariges is in die fleur van hul lewe of daar net verby. Hul mag sekere van hul kragte kwyt wees maar dit kan dikwels deur ondervinding en oordeel vergoed word en alhoewel hul kragte in die jare daarna mag afneem kan die totale produksiekapasiteit van daardie jare aansienlik hoog wees. Inderdaad is daar talle bejaardes wie se lot nie deur werkgewers besleg word nie wat hul kragte tot groot voordeel van hulself en die gemeenskap inspan.

Per slot van rekening sal die individu se kragte met die jare afneem en selfs die stadium bereik wanneer hy plegtig kan verklaar, 'Ek is nog net so jonk soos altyd—vir 2 uur per dag'. Maar selfs op hierdie stadium behoort hy, in soevere as sy kragte dit toelaat, 'n bate vir die samelewning te wees instede van 'n las. Hierdie beleid word erken en tot 'n mate uitgevoer in die geval van die jongers wat as gevolg van siekte of ongevalle vermink of ongeskik is maar dit word nie op die baie groter groep bejaardes toegepas nie.

Die grondslag van ons ekonomiese stelsel is 'n beheerde tekort en oorproduksie word as 'n ekonomiese ewel beskou; die maatstaf vir oorproduksie is egter die gemeenskapskrag en nie sy behoeftes nie. Herinnerings van lae lone en werkloosheid maak die nywerheidswerkers vreesbevange en om redes soos hierdie is ons stelsel op die lees van die beperking van werkkrugte en produksie geskoei. Die wortel van die kwaad is die oortuiging dat werk 'n ewel is wat die gewone persoon sou vermy as hy nie nooddgedwonge in sy eie behoeftes en dié van sy afhanklikes moes voorsien nie. Derhalwe is jeugdige volwassenes van mening dat die beleid om op 60-jarige leeftyd (of selfs vroeër) af te tree tot voordeel

### EDITORIAL

### THE PROBLEMS OF OLD AGE

The health and welfare of the elderly is a subject which looms large in modern life. With the continuous fall of the death rate the people over 60 years old constitute a proportion of the population that grows greater year by year. In periods when the falling death rate is accompanied by a decline in the birth rate, as has been the case during recent times, this 'aging' of the population is still more marked.

If people over 60 cease from work the economic effect of the change in the age-constitution of the population is very great. Production is limited to the younger age-groups, and the consumer-needs of the growing mass of the elderly or aged, with those of children and young persons, become a growing charge on the producer age-groups. The policy of 'retiring' healthy and capable people merely because they have reached a prescribed age is clearly one of promoting scarcity rather than plenty. Many people at 60 are at the peak, or very little below the peak, of their capacity; what they may have lost in certain phases of vitality is often compensated for by experience and judgment; and although their future years may be years of decline the productive capacity of these years may add up to a very substantial total. Many elderly persons whose destiny is not controlled by employers do in fact use their productive energy to the substantial benefit of themselves and the community.

Eventually a person's potential will be halved by age; or even brought to that of the individual who protested, 'I am as good a man as I ever was—for two hours a day'. Even at this stage, why should he not be an asset to the community to the extent of his powers instead of a total liability? This policy is recognized and to some extent acted on in the case of younger people crippled or disabled by accident or disease, but it is neglected in the vaster field of old age.

Our economic system is based on controlled scarcity. Over production is regarded as economically undesirable; but we make the gauge for over-production not the needs of the community but its purchasing power. The industrial classes are obsessed by memories of low wages and unemployment. For reasons such as these our system favours a restricted labour pool and restricted production. There is also an underlying conviction that work is an evil which normal people would avoid if they were not driven to it by the needs of themselves and their families. The younger adults therefore regard the policy of 'retirement at 60' (or even earlier) as good for themselves and good for the oldsters. There is also the

van hulself en die ouere volwassenes strek. Nog 'n faktor is die vraagstuk van bevordering wat in die dienste hoofsaaklik op uittredings berus. Dat hierdie stelsel onlogies is, is klaarblyklik. Die gewone diensloopbaan is een van gestadige verhoging totdat dit die hoogtepunt op die aftree-ouderdom bereik om dan deur afdanking gevolg te word, asof 'n berg geklim word net om oor die afgrond af te stort instede van geleidelik af te daal.

Die beheer van die verouderingsproses en die instandhouding van die bejaarde se gesondheid geniet deesdae baie meer aandag van geneeskundiges en waardevolle resultate kan verwag word. Soos ook in die geval van ander vertakkings van die geneeskunde is samewerking met die sosiale wetenskappe onontbeerlik om die allerbeste wat geneeskunde aanbied vir die mensdom vry te stel. Produktsie kan sonder twyfel verhoog word deur gebruik te maak van die werkkrugte van bejaardes as die nodige wysigings op ekonomiese gebied bewerkstellig kan word. Die meerderheid van bejaardes sal ook gelukkiger en gesonder wees as hul dienste gebruik kan word tot dié mate waartoe hul in staat is. Daar is bejaardes met skeppingsvermoë wat sonder hulp van andere 'n vol lewe lei maar vir die meerderheid is 'n gunstige ekonomiese stelsel nodig om hul in staat te stel om hulself ten volle uit te leef.

#### VERWYSINGS

Nelson, H. (1953): S. Afr. T. Geneesk., 27, 1126 (12 Desember).  
 Ziv, W. (1954): *Ibid.*, 28, (hierdie uitgawe)  
 Hurwitz, I. M. (1954): *Ibid.*, 28, (hierdie uitgawe)

#### UITTREKSELS : ABSTRACTS

Heck, Lynch and Graves (1953): *Controlled Comparison of Eighth Nerve Toxicity of Streptomycin and Dihydrostreptomycin*, *Ann. Otol.*, 62, 101-114, through *J. Amer. Med. Assoc.*, 152, 1662, 22 August 1953)

'Heck and associates in 1951 compared the relative toxicity of streptomycin and dihydrostreptomycin in a controlled experiment. The primary objective was to note the relative therapeutic effects on pulmonary tuberculosis; as a corollary, the toxicity of both drugs was checked. Patients considered suitable for chemotherapy were alternately assigned to one of two groups. One group received drug A and the other drug B. One drug was streptomycin sulphate and the other dihydrostreptomycin sulphate.

'Which was A and which was B was not known to the physician in charge. Each patient received 1 g. daily of one of the drugs for a total of 120 days. Each drug was given to 34 patients. Dihydrostreptomycin was more consistently effective than streptomycin. Studies on ototoxicity revealed that only 2 of 34 patients who received dihydrostreptomycin had vestibular disturbances; they were subjective only, consisting of transient minimal vertigo.

'Auditory disturbances, however, were evident in 5 patients. Six of the 34 patients receiving streptomycin had vestibular disturbances. No auditory disturbances occurred in this group. The neurotoxic effects on the eighth nerve by streptomycin were predominantly upon the vestibular apparatus and of dihydrostreptomycin on the auditory apparatus.

'It may be postulated that the vestibular dysfunction is reversible because the apparatus is an older, more primitive mechanism. The newer, exceedingly delicate auditory apparatus, on the contrary, has little recuperative ability.'—(Journal Abstract).

Amund, Mary O. (1953): *On the Effects of 'Smog' Constituents*: Paper read at meeting of Amer. Assoc. for the Advancement of Science, Boston, Mass., 29 December.

Concentrations of the common smog constituents, sulphur dioxide and sulphuric acid, which are incapable of producing serious lung damage in guinea pigs when used alone, create serious and irreversible tissue damage in combination. Guinea pigs exposed to a combination of 89 parts per million of SO<sub>2</sub> with 8 mg./m<sup>3</sup> of

question of promotion, which in the services depends chiefly on retirements. How illogical the system is comes out when we consider that the normal career in the services is steady promotion up to the age of retirement and then dismissal; as if one climbs the mountain slope only to fall over a precipice instead of descending a pleasant declivity.

The control of the aging process and the maintenance of the health of the aged is a subject that is assuming greater prominence in medicine, and promises valuable results. As in other branches of medicine the co-operation of social economics is essential if mankind is to obtain the maximum benefit from what medicine has to offer. That production could be increased by the cultivation of the productive capacity of the elderly and aged there is no doubt, provided the necessary changes in labour economy were devised and brought into effect, but it is also a fact that the majority of old people would be better in health and happiness if they were provided with productive occupation suited to their capacity. There are creative spirits who in their old age can fill their lives without the help of others, but the majority need the background of a favourable economic system if they are to do so to the full.

#### REFERENCES

Nelson, H. (1953): S. Afr. Med. J., 27, 1126 (12 December)  
 Hurwitz, I. M. (1954): *Ibid.*, 28, (this issue)  
 Ziv, W. (1954): *Ibid.*, 28, (this issue)

H<sub>2</sub>SO<sub>4</sub> suspended in a mist show signs of respiratory distress within the first hour and become progressively worse as the exposure continues.

Dyspnea continues for 24 to 48 hours after the animals are removed from the exposure chamber; this is in contrast to results obtained with H<sub>2</sub>SO<sub>4</sub> alone, where the survivors of even a medial lethal dose (L.D.<sub>50</sub>) concentration usually breathe normally within the first hour after exposure is stopped. Lungs of animals exposed to the combination for 8 hours showed large areas of consolidation, usually involving entire lobes.

Lennox, W. G. and Jolly, D. J. (1953): *On the Hereditary Factor in Epilepsy*, at meeting of Assoc. of Research in Nervous and Mental Diseases, New York, 12 December.

Evidence accumulated from studies over a 20-year period indicates that a hereditary factor predisposes epileptics to the disease. Among 20,000 relatives of persons subject to seizures 3 times as many had epilepsy as did an equal number of draftees chosen at random in World War II.

A study was made of 173 twins, half of whom were identical, the other half fraternal. If one of the identical twins had epilepsy, the other had about an 85% chance of having the disease. If one of the fraternal twins was affected, the other had only about a 12% chance of being stricken.

Studies of the families of the fraternal twins carried out in order to discover the mode of transmission of the disease seem to indicate that the epileptic trait is recessive: both parents have to carry it for epilepsy to appear in a child.

The chance of a child being born with epilepsy—the genetic character of his parents being unknown—is one in 2,000. If one parent has the disease, the chance is one in 40. If both parents carry the genetic factor but show no sign of the ailment, the chance is about one in 6. If both parents are epileptic, the chances are very high.

The opinion was expressed that in view of the fact that effective means of controlling epilepsy are now available, his findings should not prevent individuals suffering from the disease from marrying and having children.

## WHAT CAN BE DONE FOR SENESCENTS

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The purpose of this paper is to examine some problems confronting doctors in the management of their senescent patients and to discuss certain projects which may contribute towards a healthier and happier eventide of life. A few ordinary everyday case-histories are quoted. They do not possess conundrum qualities. Nor are they told in order to laud the ingenuity and skill of some doctors, or to censure the mental torpidity or artlessness of others. They are intended to recall well-known pitfalls in the path of every medical practitioner, for in medicine as elsewhere it is human to err; though medical colleagues seldom—even less often than patients or relatives—practise the divine attribute of forgiveness. However, by irony of fate, the criticizer and criticized often exchange roles; frequently the wise and efficient doctor of the one case becomes the muddler or tinker of the next, and *vice versa*. The success or failure of treatment of an aged patient depends largely on the interest of the doctor and on the facilities provided for him by the public.

Till the age of 64 Mr. L. was a dapper, neatly dressed, energetic, sociable and successful merchant. After that, a gradual change was observed; his clothing became shabby and dishevelled, his gait slow and undecided; he grew apathetic, depressed, absent-minded and easily fatigued. His interest in his family, his business and sporting activities waned. He put on weight. He was irritable when spoken to and betrayed persecutory suspicions. His principal wish seemed to be to be left alone to doze.

The only physical sign of disease detected was some anaemia with a low colour index, and as appropriate therapy failed he was designated early senile dementia. Before long a curator was appointed to take charge of his affairs and he was consigned to an institution, where he received thyroid medication with results outstripping the patent medicine vendor's dreams. There was an almost complete reversion to his previous self. His interest in his surroundings and appearance returned, and he became active mentally and physically.

Are we wrong in assuming that an earlier thorough scrutiny of his physical symptoms, including a B.M.R. estimation, would have averted a catastrophe? The belief is widely held that there is lack of knowledge and skill to prevent the progress of chronic diseases associated with old age, and that medical science cannot yet restore health to senile bodies, or counteract the incidence of degeneration in aging organs.

Not infrequently, one is suspected of inhumanity or callousness when persuading an old person to submit to ordeals of pain and discomfort, only to give him a few additional months or years of misery in which to stumble downhill.

These arguments betray a lack of acquaintance with recent progress of medicine, for it is undeniable that we can now do much more to help the aging than ever before. Unfortunately ailing oldsters often stultify the doctor's diagnostic powers and reduce to near zero his usual carefulness in examinations. Obvious and easily remediable conditions are, therefore, missed.

Another obstacle, is the unreasonable idea that it is futile to exert oneself for old people because the inevitable

laws of nature mock our efforts. Hence the misdiagnosis in the case of Mr. L. and in the case of Mrs. D. which follows.

Mrs. D. a retired school mistress of 80, always meticulously clean and tidy, developed a foul-smelling blood-stained faecal discharge from the rectum, and incontinence of urine. She complained of abdominal pain, giddiness, nausea, vomiting and headache. Thin and wasted, she had a dry furrowed tongue, rapid pulse, subnormal temperature, low blood pressure; and was muttering to herself and picking at her bedclothes. The abdomen was distended and doughy; there was no rigidity. A diagnosis of 'intestinal obstruction with overflow' was made by the locum tenens, and 'confirmed' by a consulting physician.

After the family had given reluctant consent to a laparotomy, and the patient, desirous of peace, agreed, a rather belated finger exploring the rectum, discovered a hard tumour the size of a naartjie, which was not attached to the bowel; it could be indented and fragmented with difficulty—a faecal mass which was later evacuated by careful *morcillement*. The patient slowly recovered and her aging companion became an addict to mag. sulph. and paraffin. liq.

Said the locum, 'I was misled by the nurse, who reported an excellent result from the enema which I ordered the day before'. Said the consultant, 'My impression was that all the necessary abdominal investigations had been done before I was called in to give an opinion on the patient's heart'.

As yet modern medicine cannot offer the geriatric patient any dramatic or quick or permanent cures; nevertheless it has much to its credit.

Take the record of Mr. A., aged 66, who entered the Jewish Aged Home looking much older than his years. He had congestive cardiac failure, was water-logged and could not walk a few yards without being halted by anginal pain. After judicious treatment with digitalis, mercurials and haematinics, he now feels healthier and happier, can walk in comfort to the dining-room and garden and participates intelligently and pleasantly in discussions on philosophy, religion and politics. If only Malan and Ben-Gurion and Churchill would descend to visit him, he could help them to solve all their problems!

Moreover many of the hardships and torments of later maturity are avoidable or remediable by anticipatory action aimed at preventing them from getting an octopedian hold of the individual and sapping his strength; we do possess the means of staving off many disastrous effects of disease and wear and tear of years.

Mr. B., aged 68, was sent in to the same institution 'to die in a Jewish atmosphere'. Five years previously he had one leg amputated for diabetic gangrene. He now had vascular occlusion and incipient gangrene of the other leg, as well as septicemia and a high degree of hyperglycemia. Two years have now elapsed since his admission, and although most of his perambulation is done in a wheel chair, he launches out now and then on crutches. One is justified in claiming that the direction of his diet, insulin and toilet of his foot have not only saved him a second amputation but have prolonged his life.

The late Mr. K. entered the Home because malignancy had recurred in his prostate; he was now inoperable. Organotherapy, medicaments and occasional manipulation kept him alive and active in comfort, and he derived a tremendous amount of pleasure by acting as librarian to the Home for several years. His last years were happy ones, though he knew the diagnosis and prognosis of his condition.

Before becoming an inmate Mrs. F. was bedfast for 2 years as a result of hemiplegia. In addition she was helpless and aphasic. At the institution her treatment did not differ much from that which she received at home. It included, however, more physiotherapy,

patient-coaxing and encouragement. She is now ambulant, her speech is fairly intelligible; she can control her sphincters, attend to herself in the lavatory (a very important and pleasing achievement) and read a newspaper. I cannot vouch that she understands what she reads—but then how many do?

Usually the Home does not accept people under 60. An exception was made in the case of Mr. D., aged 50. He was deaf, diabetic and penniless, and had lost his job because of incapacitating rheumatoid arthritis and asthma. His mother was a resident of many years. He arrived in an ambulance—obese, lethargic, dejected, helpless and neglected, groaning and begging for medicine and food to relieve his pain and insatiable hunger and thirst. For the first few weeks one despaired of ever being able to help him; the temptation to run away and leave him to his fate was great. But there is a Talmudic dictum that to save a single life is as great a deed as saving the whole of mankind. So our honorary medical staff and especially the nursing staff set to work. He is still over-parsimonious in expenditure of adipose tissue and energy, but he is ambulant, capable of attending to his wants, and has expanded his interests to the extent of declaring his love for work and independence, and to be desirous of taking on a job.

The records of similar institutions and the files of most doctors are full of many similar achievements, but because the medical profession considers them as nothing out of the ordinary and claims no praise the world is unaware and annoyingly unappreciative.

Of course our failures outnumber our successes. All our efforts, therapies, consultations, encouragements and chastisements can do but little to stave the progress of Parkinsonism, or arteriosclerosis or neoplasms. This, is largely due to inadequate co-operation and the inadequacy of funds for medical purposes and research, and of facilities for the treatment of the diseases and degenerations which run parallel with old age.

#### CAUSES OF DEGENERATIONS OF OLD AGE

Of the many crippling handicaps associated with old age only a few are due to old age itself. Social and economic maladjustments play at least as important a role. Often careful examination and critical history-taking may reveal that minor deviations or domestic irritations are the cause of symptoms marring the oldster's health and happiness.

Mr. G., aged 70, was suffering from asthma, which for years was controlled by infrequent ephedrine and adrenaline. Then his attacks increased in frequency and intensity. Even adreno-corticotrophic therapy gave inadequate relief. Careful assessment of his history revealed that his symptoms became worse after his book-wise and dogmatic daughter-in-law assumed control of household affairs. Domestic rearrangements were more effective in diminishing the severity and frequency of his attacks than most modern therapy.

Some disabilities of the aged are the aftermath of protective adaptations primarily assumed to guard an injured limb against further pain or damage, but in the manner of a faithful dog standing watch over an unconscious master, keeping off friend and foe alike; so that these protective measures linger on beyond their period of usefulness, and by their persistence handicap rather than help recovery. An example of defence overtones which survive their purpose are the rigidity and immobility following a stroke. Indispensable in the early stage of the disease, they cripple the patient permanently unless purposeful medical and physical therapy is instituted in good time to counteract them.

*When is a person old?* The aging process and life-span of animals differs from one species to the other; a fruit fly completes its life cycle in about 21 days, while an

elephant lives to 150 years and more. Even in the same species, there is an appreciable variation in the rate of aging.

It was held that the number of years a person has lived could be used as a measure to determine whether he is young, middle-aged, senescent or old. It is now accepted, however, that a person's chronological age is not a yardstick for his mental or physical capacity. Not all people past 70 should be relegated to the armchair. Many at 60 are more capable and energetic than others at 30. The alertness, energy and efficiency of Bernard Shaw, Bertrand Russell, Einstein, General Smuts, Dr. Malan and many others, after they had passed their 70th birthday, could put to shame persons less than half their age.

*Asymmetry of Aging.* What is more, there is asymmetric aging in the different parts of the body or systems of the same individual. Some tissues deteriorate and cease functioning, while others are still at the height of their activity. The ovaries, for example, betray unmistakable signs of senility long before other organs; frequently the coronary arteries of the heart evince serious arteriosclerosis while the other arteries are still soft and pliable. The cells of the bone-marrow and epidermis seem to have an interminable life-span.

*Cause and Effect Differ in Young and Old.* A child cannot describe his sensations or locate the cause of trouble; he is unable to help the doctor in his diagnosis; nature, however, compensates for his shortcomings. The child's signs of disease are explosive, abrupt and conspicuous; he seldom harbours more than one pathological condition at the same time. This facilitates naming the illness. On the other hand, diagnosis of disease in an old person is made excruciatingly difficult by his suffering simultaneously from several ailments, each one of which complicates and disguises the other, and by the fact that diseases in the old develop slowly and imperceptibly, and blend so thoroughly with the structure and appearance of the host as to seem to form part of his original constitution.

A patient complained of epigastric pain and flatulence aggravated by food. The pain radiated round to the back and down one or both arms. He was undecided about the effects of exertion or posture on his discomfort. There was some tenderness in the right hypochondrium. Auscultation and palpation betrayed no abnormality of the heart, but the cardiograph recorded cardiac embarrassment. Further investigation proved him to be suffering from coronary insufficiency, cholecystitis and a hiatus hernia.

In another patient who was treated for microcytic anaemia for months, the ultimate diagnosis turned out to be gastric neoplasm and chronic nephritis, with of course some anaemia.

When young and old are subjected to the same traumatizing influence, the damage sustained and the rate and thoroughness of their reaction and recuperation are of different magnitude. For this reason, methods of diagnosis and treatment and criteria for assessing progress have to be modified to suit each age-epoch. It has been computed that every 5 years of life adds 24 hours to the period required for convalescence from an acute disease or injury. An accident which may bring about a serious condition in an old person and convert him into a permanent invalid, or even prove fatal, may do nothing more to a young person than bruise his limb or his pride.

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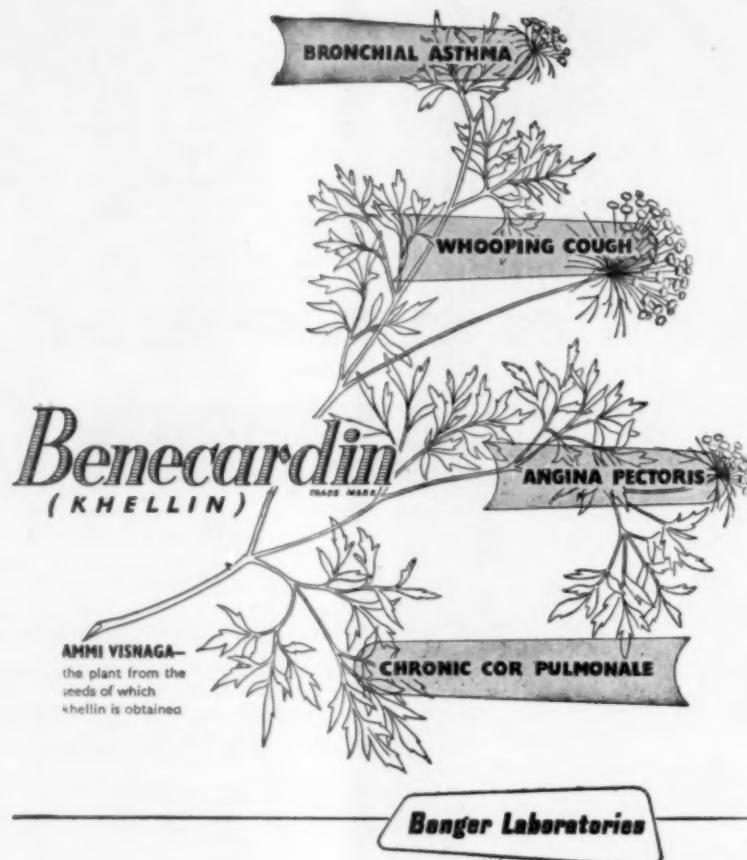
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Grandpa aged 68, accompanied grandson aged 8, for a walk. On the way they rested on a bench, which collapsed, spilling them both on the ground. The child immediately started howling and yelling; there were numerous willing helpers but his screams increased as the crowd grew. 'Leave him alone', ordered the first aider, 'he's got concussion of the brain, a dislocated vertebral column, and a closed fracture of the humerus'. The old man scrambled to his feet with difficulty and tried to soothe the hysterical youngster, but as he moved he limped and was forced to sit down. Nevertheless he protested that he had only sprained a muscle; he was full of apologies for inconveniencing all and sundry. The ambulance which took the child to the hospital allowed the old man to come with him as company, and there the only injuries found on the youngster were a few minor skin abrasions, while the old man, who shyly asked the nurse to put a little iodine on his sprained muscle, was discovered to be suffering from a fracture of the neck of the femur.

A germ infection of an intensity to set up a high temperature, delirium and other alarming symptoms in a young person may evince very few visible effects—though none the less grave—in an elderly person. Compare the unequivocal and self-advertising symptoms and signs of acute appendicitis in the young person, with the shy, almost symptomless, and apyrexial, ruptured appendix in the old.

#### NEED FOR ORGANIZATION

It is obvious that in order to deal satisfactorily with the needs of old people, an organization must be established which should include doctors, nurses, social scientists, economists and others, who should act in co-operation. The medical profession will, however, have to be the centre round which the whole scheme will revolve.

*The Geriatrician.* The unprecedented recent advances in all fields of medicine demand of every doctor vast and multidimensional scientific acquisitions, but this is especially required of the doctor attending the aged. He need not necessarily be a specialist in geriatrics but his diagnostic acumen must be high. His knowledge should be encyclopedic in every department of medicine—an ideal impossible to attain.

The geriatrician requires enthusiasm, zeal, hopefulness and above all a dynamic approach, with determination to be discouraged neither by the obvious limitations of our present knowledge nor by apparently insurmountable difficulties. It is, therefore, heartening to realize that the healing faculty does not depend entirely on technical skill; sympathy and personality and ability to inspire confidence are at least as important; for the patient who has confidence in his doctor or faith in his God does best. This may explain why the laurels of popularity do not always go to the most learned or most efficient doctor—not even to the most successful.

In addition, the geriatrician (and what follows applies equally to the old peoples' nurse) requires a combination of rare qualities of character and mind; the patience of an angler, for objective and subjective signs of improvement procrastinate their manifestations; and the tolerance and indulgence of Hillel, for old people are often niggardly in signs of appreciation, leave alone gratitude, for exertions on their behalf.

Any schemes evolved for their guidance have to be flexible to suit the changing requirements of elderly folk as they advance in years. No sooner is one complaint removed, then another, real or imaginary, replaces

it; this is apt to make attendants despondent or uninterested.

#### THE NEED FOR A GERIATRIC UNIT OR HOSPITAL

No individual possesses the knowledge, ability and patience to satisfy all these requirements; nor can one profession or discipline overcome all the heads of the hydra of old age. Nevertheless a partial solution can be achieved by an organization in which doctors, nurses, social scientists, economists and others work in unison, with facilities for the preservation of health and for diagnosis, care and treatment. As a practical measure a hospital is a suitable rallying point for such an organization. When tolerably well the aged should be encouraged to live with younger people and play an active role in the life of the community. In illness they should be treated either at home or at ordinary hospitals, the same as patients of other ages. When, however, difficulties are encountered in placing them at a nursing home or hospital, or if their recovery is unduly protracted, there should be special geriatric hospitals or units to which they could be transferred for further investigation and treatment.

Hospitals and nursing homes are reluctant to admit elderly patients, and before they accept them even on sufferance the overtired and harassed doctor has to submit himself to a time-consuming and humiliating cross-examination by a bumptious and inexperienced young houseman, or by a sympathetic sister who is restrained by being over-solicitous for the wishes of her honoraries. These facts alone justify the setting aside of special beds, units, or hospitals for the accommodation of the aged. There are, however, many other reasons, some of which will be mentioned. Hospitals are needed for the elderly and aged, adequately equipped with apparatus, laboratories and technicians; and the most urgent and difficult task ahead is to persuade the proper authorities to establish them.

(1) *Diagnosis and Treatment.* The primary purpose of such a hospital would be to investigate and treat diseases and disabilities which are abnormal concomitants of senescence, but it would concern itself no less with giving advice on all problems affecting senescence, and with the preventive aspect of geriatric medicine. It would thus supply many services which are at present neglected. It would be staffed by a team of experienced doctors, auxiliaries and nurses qualified temperamentally and academically and prepared to dedicate their talents to assist senescent individuals, and thus make geriatrics their chief professional interest. By word and deed they would show the in-patient, that he is not an intruder or an unwelcome tenant, but that the hospital and its personnel are capable and keen to help him with all scientific means, sympathy and equipment at their disposal.

Each patient's programme for investigation, treatment and re-education should be individualized and geared to the greatest degree of physical and mental efficiency, self-confidence and independence commensurate with his capacity. It will be necessary to consider the aging human organism as an indivisible psychosomatic unit, and not as a disintegrating federation of autonomous

systems. The individual should receive greater attention than his disease, and thus the lie should be given to the jibe that doctors are more interested in the patient's disease than in the patient himself, in the diagnosis than in the treatment.

At first, however, it may be expedient to campaign for the establishment of out-patient clinics only, for the demand for special units or hospitals may meet with much resistance. Hospitals will follow, once the public sees the value of the clinics.

(2) *Periodical Medical Examinations.* As childhood is the period during which the individual is educated and conditioned for a healthy and useful adult life, so is middle age the appropriate time to train and prepare the adult for a healthy and pleasant senescence, and for excluding chronic ill-health.

To institute effective measures for preventing a disease from becoming chronic, it must be detected in its initial stage, in the silent symptom-free phase; if possible, even before the patient himself is conscious of it. As many chronic diseases have their beginnings early in life, this ideal is achievable if every person of middle age and beyond submits periodically to a head-to-toe examination at an appropriate institution, and every part of the body is carefully checked, and not merely the system which is suspected to be faulty.

Mrs. N. was annoyed when the boat taking her on a round-the-world tour was delayed for a few days at the first port of call—a place in which she was not interested. Bored, she read and so came across a popular medical article which convinced her that she had heart disease. She visited a doctor, who declared her heart normal; but he discovered a small 'cyst' not larger than a split pea in one of her breasts, of which she had been unaware. The tumour was removed and under the microscope found to be a carcinoma. Her tour thus had an abrupt ending, but 5 years have now elapsed since that episode; the woman is alive and healthy and there has been no sign of recurrence.

Mrs. N.'s story is a gratifying one, proving the value of optional medical examinations. The case of Mr. T., however, is heart-breaking, but it emphasizes the lesson. For 60, Mr. T. looked young and felt young. Since his cholecystectomy 3 years earlier he saw no doctors professionally. One day he developed abdominal discomfort and the doctor felt a mass in his hypogastrum which was later found to be a neoplasm requiring extensive resection. Mr. T. maintains that till that day, except for a minor transient episode, he had no symptoms of any kind.

Is one entitled to assume that if Mr. T. had seen a doctor earlier, the sequel might have read differently? We believe so.

It would be a function of this hospital to offer to patrons facilities for a thorough periodic physical and psychological check-up, making an inventory of their capacities as well as incapacities and trying to detect and counteract development of disease as early as possible. The record would be utilized for comparison with future re-examinations, and as a basis for advice to examinees on the preservation of health, and on living within the limits of their maturing or aging system; for just as much harm can ensue from over-encouragement as from over-cautiousness. Often the competence and strength of individuals deteriorate long before they are ready to admit it or able to recognize it. Advice to aging or handicapped persons should, therefore, come from experts only.

(3) *Research.* Furthermore, these records as well as those of patients treated, would furnish additional data for research into the cause and progress of disease and degeneration.

(4) *Training Centre.* Very few adults can recall or understand the mechanics of their childhood mentality or the motives which prompted what they did and said. If they do remember, they appear to them in retrospect senseless and foolish. And this is true of an age phase from which all have emerged (at least chronologically). It is therefore understandable if young and middle-aged people fail to comprehend the mind of an oldster—an age phase of which they have no experience.

The hospital would provide opportunities to doctors, students, nurses and others to observe and study the physical and psychological changes which evolution and involution bring about in senescents, and so facilitate the understanding of the ideas which impel the utterances and the actions of the old. This would enable them to be sympathetic towards apparently unreasonable and capricious behaviour. *Tout comprendre, c'est tout pardonner.*

In the medical domain, practice at the hospital will provide education in the recognition of incipient signs of somatic and mental aberrations. The hospital will thus constitute an ideal training centre in the art of attending elderly patients.

The hospital, by co-operating with medical and nursing schools, will benefit from their knowledge and experience and from their therapeutic and research resources, and in return should provide instruction in geriatrics to students and graduates.

(5) *Residence.* A single factor which influences the happiness and welfare of the oldster more than the combined effect of many causes is the physical and social milieu of his place of residence. Its four walls limit his horizon for many a day; his fellow residents and infrequent visitors constitute his only contact with the outside world. One seldom meets an old person content with his habitation. This is largely due to the fact that there is no agency competent to select and recommend accommodation which should fulfill the individual's medical, social, intellectual and physical requirements; at present the accommodation of the aged is mainly determined by their financial capacity, and with inexpert guidance. It is therefore envisaged that one of the functions of the organization will be to provide expert advice on the choice of suitable residences for oldsters.

(6) *Occupation and Recreation.* Occupation not only provides the means for support of oneself and dependants but also helps to maintain body and mind in sound condition. Voluntary or imposed inactivity results in physical disintegration and mental deterioration. Very often a mental state ostensibly due to senile deterioration is in reality caused by idleness.

Forty years' careful planning and hard work ('good fortune' it is often called) enabled Mr. R. to build up a vast industrial concern with numerous overt and covert ramifications. He also acquired responsible social and political positions. Then his helpmate and confidant—his wife—died. From that moment he lost the zest for life. He handed over the management of his organizations to his only son, while he himself vegetated serenely. 'Reactive depression' was the verdict of some, 'senile dementia' of others, but the nett result was that he deteriorated by the day; he often repeated the *leit motif* of Koheleth (Ecclesiastes), 'Vanity of vanities, all is vanity'. Nobody took more notice of him.

Several years passed; he remained a forgotten man, till his son met with a serious and disabling accident. It was then discovered that the business was in a bad state, and that for the last few years

it had been kept out of the bankruptcy court only by the skilful manipulations of Mr. R. Junior. As the nominal head the old man was acquainted with the position and made to realize that not only did this spell ruin and disgrace for himself but that hundreds of employees and an even greater number of investors and shareholders faced disaster. There was general astonishment and misgiving when the patriarch girded his loins and resumed active control of his affairs. He took on a new lease of life. Within two years he restored to his business its previous prosperity, and to himself, his lost sagacity, interest and appearance.

In the majority of cases, however, as man grows older and aware of his waning powers he clutches at some form of activity or pretence, often beyond his capacity, in the hope that it will delay his propulsion towards the precipice of obliteration. For this reason the Organisation should have a department which after assessing the intellectual and physical aptitudes of the individual, would initiate residents and non-residents into occupations and hobbies for recreational, therapeutic and earning purposes. Its guiding principle should be to train elderly persons to compensate for defects by utilizing to the full, but not overstraining, their remaining capacities. The new pursuits should be creative; Tolstoy was right when, in his pre-nihilistic days, he wrote, 'The only true pleasure is creative activity . . . Without creation there is no true pleasure, none that is not tinctured with anxiety, suffering, pangs of conscience, shame'. It should call for a modicum of both physical and intellectual effort, and carry a promise of approbation or reward, for even in old age, it is 'the expectation of reward that sweetens labour'.

New vistas should be opened up by learning new skills—if thought advisable. Everything should be done not for the old people but with them; they should be encouraged to do as much as possible for themselves, and maintain their independence; over-pampering is as capable of undermining their *moral* as neglect. In their choice let them ponder over Dr. W. B. Wolfe's dictum

' . . . it is only by putting the focus of their activities upon some movement or activity greater than their individual ego that they can attain peace and security in old age'.

This by no means exhausts the list of functions which such an organization and hospital would assume.

#### SUMMARY

An organization should be formed to initiate and co-ordinate activities for the welfare of the aged, and to take the lead in the establishment of a special Geriatric Hospital or Unit.

Such a hospital is necessary because:

(a) Senescents suffering from degenerative diseases are not welcome at ordinary hospitals, where in any case the personnel is not sufficiently interested or equipped to cater for their needs.

(b) This hospital will provide training facilities for doctors, nurses and auxiliaries in understanding and caring for the elderly.

(c) It will provide opportunities for research in the process, cause and therapeutics of degenerative diseases and senility.

(d) It will provide expert advice on the placement of elderly persons according to their medical and other needs.

(e) It will have facilities for periodic medical check-up and guidance of all individuals, so as to detect diseases at their very beginning, and prevent or retard the development of chronic deteriorations.

(f) To counteract the loneliness and boredom to which elderly persons are prone, it will organize for visitors and residents recreations, activities for gain, therapy and social intercourse.

## OVULASIE—'N NUWE BEGRIP

D. A. H. DU TOIT, M.B., CH.B. (KAAP), M.D. (GINEK. EN VERLOSK. LEIDEN)

Kaapstad

Om die normale ontwikkeling van 'n fisiologiese proses te verstaan moet soms nie alleen normale struktuur en funksie bestudeer word nie, maar ook abnormale strukture en afwykings van die fisiologiese funksie. Die proses van ovulasie is seker die mees belangrike funksie van die vroulike individu—dit is die eerste en belangrikste vereiste vir die voortplanting van die geslag en die natuur leer dat die funksies wat te doen het met die voortbestaan van die geslag die basiese en mees essensiële plek inneem in die lewe van die organisme. Dit is daarom dan ook so nodig dat ons 'n juiste begrip kry van die proses van ovulasie.

Daar is reeds geweldig baie navorsing gedoen i.v.m. ovulasie in die mens en in verskillende diersoorte, maar die belangrikste ontdekking bly nog steeds die van Graaf—die man wat die follikel vir die eerste keer beskryf het. Sindsdien is daar 'n groot aantal feite ontdek

omtrent die follikel en die proses van ovulasie, maar nogtans berus baie van ons begrippe van die follikel en sy funksie op gissings en veronderstellings. Die vernaamste redes hiervoor is die feite dat weefsel van die menslike ovarium nie so maklik verkrygbaar is nie en dat menslike eksperimente maar van 'n beperkte omvang kan wees. Daarom is dit dan ook dat die vecartse so 'n groot bydrae gelewer het tot die begrip van ovulasie en voortplanting in die mens.

Daar is 'n paar histologiese feite wat van groot belang is by die studie van ovulasie. Daar is drie groepe van selle wat 'n belangrike rol speel in die proses van ovulasie nl. die granulosaselle, die thecaselle, en die stromaselle. Dit is belangrik om te onthou dat die thecaselle werklik alleen maar stromaselle is wat 'n veranderde vorm aangeneem het, en sodoende ook 'n ander funksie. Waar daar 'n vermeerdering en uitbreiding van thecaselle is,

moet dit dus nie gesien word as 'n invasie van die stroma deur thecaselle nie, maar as 'n progressiewe verandering of omskepping van stromaselle tot thecaselle. In die fisiologiese proses van ovulasie bestaan daar nie soets as 'n aktiewe indringing van thecaselle tussen die stromaselle in nie.

By die studie van honderde seriesnitte van ovariumweefsel wat hy onderneem het in verband met sekere patologiese afwykings van die ovarium, het die skrywer insidenteel sekere belangrike en nuwe waarnemings gedoen. Hoe hierdie waarnemings help tot die beter begrip van ovulasie sal blyk uit die onderstaande. Die monsters van ovariumweefsel wat bestudeer is, was almal afkomstig van ovaria waarin daar meerder kistes voorkom het d.w.s. weefsel van polikisteuse ovaria.

Die bestaan van follikelkistes in die ovarium is algemeen bekend, maar die ontstaan van die kistes en die fynere patologiese histologie daarvan is maar gebrekkig bestudeer tot 'n kort rukkie gelede. Een van die opvallendste verskynsels wat waargeneem kan word in so 'n weefsel is dat die follikelkistes vrywel altyd in 'n baie losmasige weefsel lê. Die follikel is feitlik altyd omring deur weefselsplete (Fig. 1). Dit is 'n waarneming wat deur enkeles reeds vantevore gemaak is, maar niemand het nog probeer om 'n duidelike verklaring vir hierdie opvallende bevinding te gee nie.

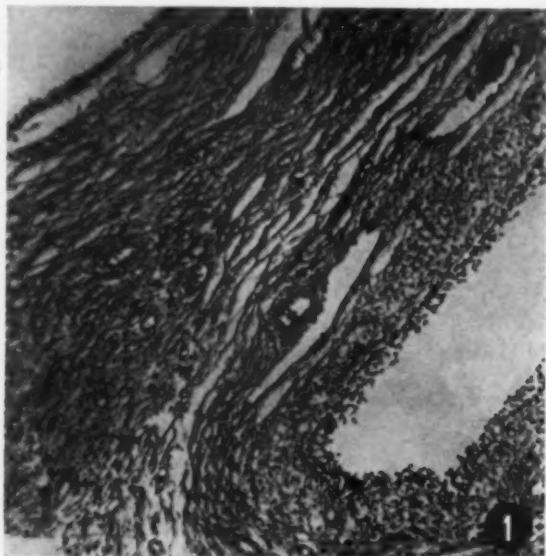


Fig. 1. Holte van follikelkiste is regs te sien. Disintegrerende granulosaselle. Thecaselle sterk gevakuiseerd. Follikelkiste is omring deur groot aantal weefselsplete.

Wanneer 'n follikelkiste, afkomstig uit 'n polikisteuse ovarium, histologies beskou word, dan blyk dit dat die muur van die follikel verskeie vorms kan aanneem. Gewoonlik is die follikel uitgevoer met 'n binnekste dun lagie granulosaselle wat dan minder of meer degeneratiewe verskynsels vertoon (Fig. 1). In sommige van die kistes het die granulosa-lagie reeds heeltemal ge-

degenereer en is met hyaline-weefsel vervang (Fig. 2). Onder die granulosa-lagie is daar dan 'n taamlike dik laag thecaselle en dit is dan ook in hierdie laag waarin die karakteristieke veranderinge voorkom. Die thecaselle vertoon gewoonlik luteine-veranderinge. Dit is nodig om vir 'n oomblik stil te staan by die gebruik van die term 'luteine'. Oorspronklik was dit die term wat gebruik was vir selle wat geel voorgekom het as gevolg van die aanwesigheid van 'n gepigmenteerde vet in hulle. In die jongste tyd is daar egter 'n neiging in die literatuur om 'n weefsel alleen as 'luteine' te bestempel wanneer dit progesteron in meetbare hoeveelhede produseer. Dit is egter my mening dat dit 'n onnodige beperking van die term is en dat die term toegepas behoort te word op alle granulosa- en thecaselle wat makroskopies geel is en wat histologies die veranderinge (vergrotting, vakuolisatie ens.) vertoon wat gewoonlik gepaard gaan met so 'n makroskopiese beeld.



Fig. 2. Follikelkiste. Groot en klein weefselsplete in weefsel om follikel. Byna al die thecaselle is helder. Die laag van thecaselle het 'n losmasige en sponsagtige voorkoms. (a) Holte van kiste. (b) Granulosaselle met hyaline-weefsel vervang. (c) Dik laag sterk gevakuiseerde thecaselle.

Die geluteiniseerde thecaselle om die follikelkistes neem gewoonlik verskillende vorms aan. Die selle is almal vergroot, het die ronde vorm verloor en is nou meer veelhoekig. In sommige is die selplasma egalig en donker gekleurd terwyl in ander dit meer korrelrig en



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selfs sponsagtig is. Die selkerne van hierdie selle is ovaal en taamlik lig van kleur. In die meeste selle is die proses van luteinisasie egter iets verder gevorder en kom daar klein vakuoles in die selplasma voor. Hoe ouer die sel word hoe groter word die vakuoles en uiteindelik smelt hulle saam en vorm een groot vakuole. Hierdie eindstadium word gekenmerk deur 'n sel waarin byna die gehele plasma vervang is deur 'n groot vakuole en waarvan die kern in 'n laat stadium degeneratiewe verskynsels begin vertoon. Die sel kom helder en leeg voor (Fig. 3).

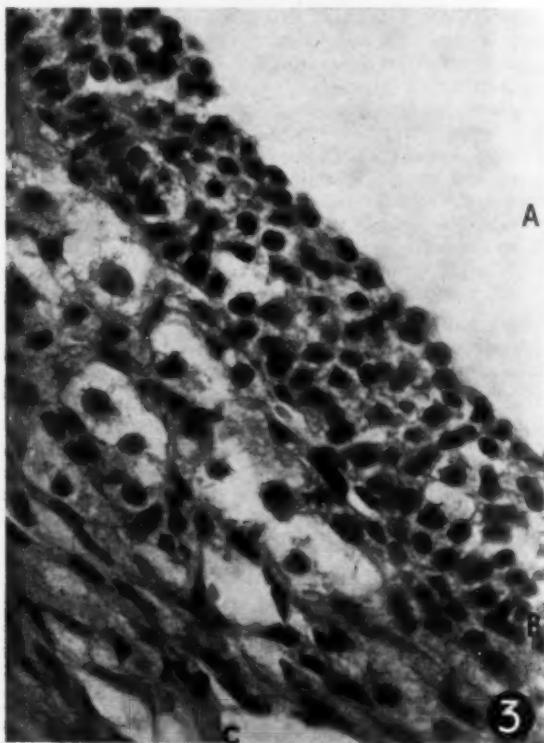


Fig. 3. Follikelkiste. Regs bo (a) is holte van kiste te sien. Kiste is uitgevoer met 'n laag granulosaselle, (b) en daaronder 'n laag gevakuoliseerde thecaselle (c).

Wanneer die veranderinge in die thecaselle nog verder opgevolg word dan sien ons dat daar op sommige plekke langs die kiste hele groepes van hierdie helder thecaselle voorkom. In nog 'n later stadium verdwyn die selmembraan tussen sommige aangrensende helder selle en die vakuoles smelt saam. Die gevolg is dat daar nou groot ovale ruimtes in die stroma ontstaan. Later verdwyn die selmembraan om nog groter getalle van aangrensende selle en daar ontstaan nou nog groter ruimtes in die weefsel en die enigste aanduiding dat daar oorspronklik thecaselle in die plek van die ruimtes was, is die enkele klein swart gedegenereerde selkerne wat hier en daar nog oorbly. Met verloop van tyd word die ovale ruimtes afgeplat en word gesien as puntige weefsel-

splete. Omdat die luteïne selle in kosentriese lae om die follikel ontwikkel, lê die weefselsplete ook koncentries gerangskik om die follikels. Veel later word die splete ingeneem en vervang deur 'n losmasige netwerk van jong bindweefsel waarin daar 'n groot aantal nuutgevormde haarvate is. Die samesmelting van die helder selle en die vorming van ruimtes in die weefsel as gevolg daarvan kan duidelik gesien word in Fig. 4 en ook tot 'n mate in Fig. 3. Fig. 4 is 'n hoë vergroting van die thecaselle wat om die follikel in Fig. 2 voorkom.

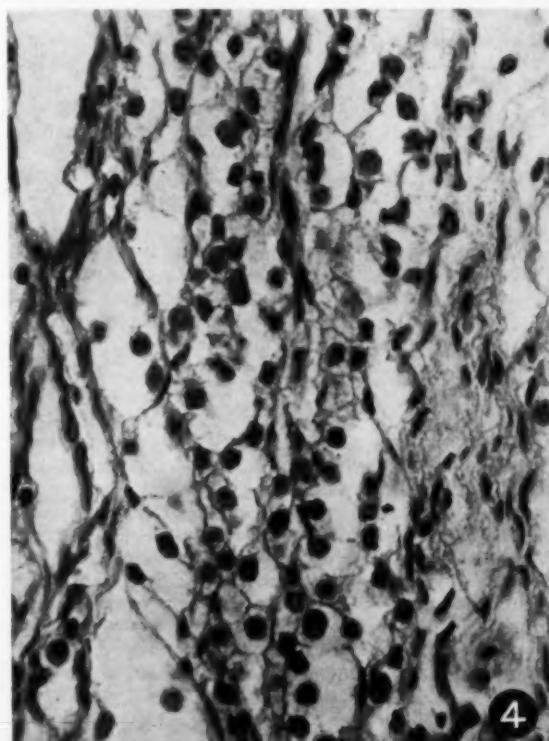


Fig. 4. Hoë vergroting van thecaselle in fig. 2. Baie van die selle is tot so 'n mate gevakuoliseerd dat hulle as helder selle voorkom. Die selmembraan van sommige aangrensende selle het verdwyn en die holtes in die selle het saamgesmelt sodat ovalevormige ruimtes in die stroma gevorm word.

Die ruimtes wat in die weefsel om die follikels voorval word dus gevorm deur verouderde geluteiniseerde thecaselle wat opbrek en saamsmelt. Hierdie thecaselle ontstaan oorspronklik uit die stromaselle van die ovarium.

In polikisteuse ovaria kom daar dikwels ten dele saamgevalle en atretiese kistes voor. Hierdie atretiese follikels vertoon veranderinge waaruit belangrike afleidings gemaak kan word. Die kiste is gewoonlik samegevalle en kom voor as 'n langwerpige afgeplatte holte met twee skerp punte aan die twee ente waar die wande van die kiste reeds heeltemal saamgeval het. Die holte van so 'n kiste is vir die grootste gedeelte uitgevoer

met 'n dun lagie hyaline-weefsel wat die granulosa vervang. Hier en daar is daar egter nog reste van die granulosaselle te sien. Aan die buitekant van die gedegenereerde granulosa is daar 'n taamlike dik laag thecaselle. Hierdie selle bevat meesal 'n sponsagtige selplasma, maar in sommige kom daar 'n aantal klein vakuoles voor, en 'n paar van die selle is tot so 'n mate gevakuoliseer dat hulle as helder selle vertoon. Die grootste aantal van helder selle d.w.s. sterk geluteiniseerde selle kom voor in die gedeelte van die kiste wat die mees verouderd is; in ander woorde, in die samegevalle gedeeltes. Omdat die vakuolisatie en vorming van helder selle op sy sterkste is in die gedeeltes van die kiste wat die oudste is, is dit duidelik dat die helder selle 'n eindstadium van luteine-veranderinge in die thecaselle verteenwoordig. Die mate van vakuolisatie dus ook tot 'n groot mate die ouderdom van die selle aan en kan dus gesien word as 'n ouderdomsverskynsel in die geluteiniseerde thecaselle.

Nogmaals is dit miskien gewens om daarop te wys dat die thecaselle wat so 'n abnormale follikel (en ook die normale follikel) omring ontstaan uit die stromaselle van die ovarium. Waar 'n follikel ontwikkel, normaal of abnormaal, is daar in mindre of meerder mate 'n stimulering van die aangrensende en omliggende stromaselle. Die stromaselle ondergaan 'n besondere vorm van hiperplasie nl. luteinisatie. Luteine-thecaselle is dus niks anders as vervormde stromaselle nie.

Wanneer ons nou tot die normale follikelgroeи en ovulasiе kom is daar 'n paar bevindinge en gedagtes wat die moeite wert is om aan te haal. Wanneer follikel-groei histologies bestudeer word kan dikwels waargeneem word dat die theca interna selle van klein Graafse follikels reeds 'n taamlike mate van luteinisatie vertoon en dit veral gedurende die groeiperiode van die follikel. Wanneer die follikel volgroeid is, is daar nie meer so baie gevakuoliseerde thecaselle te sien nie en teen die tyd dat die thecaselle tussen die granulosaselle infiltraties daar geen gevakuoliseerde thecaselle meer te sien nie. Gedurende die groeiperiode van die follikel is die vakuoles tot die grootste mate aanwesig in die thecaselle wat tussen die follikel en die oppervlakte van die ovarium lê.

Omdat die natuur niks sonder rede doen nie, lyk dit dus of die vakuolisering van die thecaselle in die groefase van die follikel noodsaklik is vir die ontwikkeling en volwasse word van die follikel. Wanneer die follikel eers volwasse is, speel die gevakuoliseerde thecaselle geen groot rol meer nie en verdwyn die vakuoles tot 'n groot mate uit die thecaselle. Dan is dit die gevakuoliseerde granulosaselle wat die groot rol in die corpus luteum speel. Gaarenstroom en De Jongh het reeds aangetoon dat 'n androgene hormoon, soortgelyk aan testosteron, waarskynlik nodig is vir die normale ontwikkeling van die follikel. Dit lyk dus heeltemal moontlik, en selfs waarskynlik, dat dit hierdie tydelik gevakuoliseerde thecaselle is wat die 'testosteron' produseer wat dan in normale hoeveelhede die normale groei van die follikel stimuleer. Wanneer die follikel volgroeid is en tot aan die oppervlakte van die ovarium ontwikkel het en gevolleer het, is die werk van die gevakuoliseerde thecaselle afgehandel en verdwyn hulle grotendeels deur disintegrati-

sie. In die later stadia ondergaan die oorgeblewe thecaselle weer 'n mate van vakuolisatie.

Strassmann<sup>1</sup> het in 1938 reeds aangetoon dat daar 'n ongelyke ontwikkeling van thecaselle om die groeiende Graafse follikel is. Die thecaselle ontwikkel tot 'n groter mate aan dié pool van die follikel wat naaste aan die oppervlakte van die ovarium geleë is. Gewoonlik is daar om die follikel maar 'n paar lae van thecaselle, maar by die pool naaste aan die oppervlakte van die ovarium is daar 'n konus van thecaselle wat baie lae diep is. Volgens Strassmann infiltrer die selle aan die punt van die konus (wat altyd in die rigting van die oppervlakte wys) die stroma en dring deur die stroma en maak dit 'sag' sodat daar 'n area van minder weerstand geproduseer word waarin die follikel dan kan uitstoot in die rigting van die oppervlakte. Strassmann kon egter geen chemiese reaksie of destruksie in die stroma waarnem wat miskien deur 'n ensiem (of iets dergelik) van die thecaselle kon veroorsaak word nie. Daar is ook hoegenaamd geen ensiem en geen disintegratie van stromaselle waar te neem nie. Nog Strassmann nog iemand anders het al 'n verklaring gevind vir die presiese manier waarop die wig van thecaselle die follikel na die oppervlakte van die ovarium laat groei. Die verklaring hiervan het ek egter gevind, meer ek, in die veranderinge wat te sien is in thecaselle wat om kisteuse follikels voorkom.

Die groei van die follikel na die oppervlakte vind dan, volgens my mening, op die volgende manier plaas:

By die punt van die thecaselkonus ontwikkel daar gedurende nuwe thecaselle deur verandering van stromaselle en hierdie transformasie van stromaselle tot thecaselle is progressief in die rigting van die oppervlakte van die ovarium. (Die prikkel tot hierdie stromaseltransformasie kan nou nie verder op ingegaan word nie, maar dit is op sigself al weer 'n baie interessante en belangrike vraagstuk.) Die gevolg is dat die mees resente gevormde thecaselle d.w.s. die jongste selle, by die punt van die konus lê terwyl die oudste selle by die basis van die wig te vindre is. Nou het dit reeds duidelik geword uit die studie van thecaselle wat om follikelkistes voorkom, dat dit die ouer thecaselle is wat gevakuoliseerd word en uiteindelik so 'n mate van vakuolisatie ondergaan dat hulle uiteindelik as 'helder' of 'leë' selle voorkom. Hierdie sterk gevakuoliseerde helder selle sien ons ook in die grootste getalle voorkom by die basis van die thecasel konus. In die voorafgaande gedeelte is reeds beskryf hoe hierdie helder selle uiteindelik opbrek en dan ruimtes in die weefsel ooplaat wanneer hulle verdwyn. Die voortbeweging van die follikel na die oppervlakte is afhanglik van die relatiewe groot getalle van helder selle wat in die basis van die konus van Strassmann te vind is. Terwyl nuwe jong thecaselle by die punt van die thecaselkonus gevorm word deur veranderinge wat plaasvind in die stromaselle, disintegreer die ouer selle (d.w.s. die helder selle) wat nou by die basis van die konus lê en so kom daar nou nuwe ruimte vry aan die oppervlakkige kant van die follikel. Deurdat daar 'n mate van druk in die follikel heers, stoot die follikel nou uit en neem beslag van die vrygekome ruimte. Daar die ruimte steeds vrykom aan die kant van die follikel wat naaste aan die oppervlakte van die ovarium geleë is, vind die grootste uitsetting van die follikel altyd

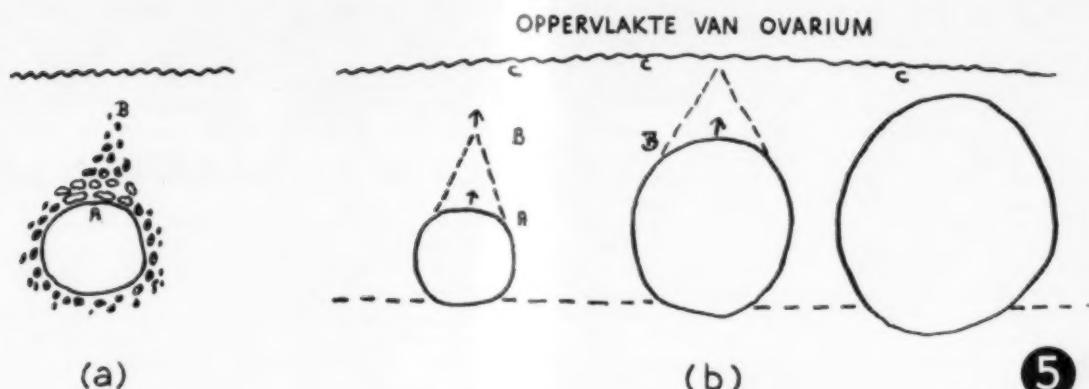


Fig. 5 (a). By A disintegreer die verouerde helder thecaselle. By B ontwikkel stromaselle tot nuwe jong thecaselle. (b) Die follikel groei in alle rigtings, maar die uitbreiding vind veral plaas in die rigting van die oppervlakte. Eers ontwikkel thecaselle by A. Later disintegreer hierdie selle terwyl by B stromaselle tot nuwe thecaselle omskep word. Nog later disintegreer die ouer selle by B ook en terselfdertyd ontwikkel nuwe thecaselle by C. Veroudering en disintegrasie van die thecaselle by C bring die follikel tot aan die oppervlakte.

in die rigting van die oppervlakte plaas totdat die ovarium die oppervlakte bereik en dan bars.

Hierdie taamlik eenvoudige verklaring van die rol wat die Strassmann-konus speel in die verplasing van die groeiende follikel na die oppervlakte van die ovarium maak dit onnodig om te spekuleer of daar 'n vernietigende of disintegrerende werking van die thecaselle op die stroma is en of dit dan sou ontstaan deur 'n 'chemiese reaksie' of 'oplossing van selle' of 'ensiemreaksie'. In ieder geval is die 'disintegrerende' en 'verwerkings'aksie van die thecaselle, soos voorgestel deur sommige, 'n baie vae en ook onbewese opvatting. Buitendien is dit ook moeilik om 'n mens voor te stel hoe die hele konus van thecaselle 'en bloc' na die oppervlakte sou kan beweeg soos voorgestel word in die tot nog toe aangename teorie van Strassmann.

Die oudste en mees gevakuoliseerde thecaselle kom dus voor in die basis van die thecaselkonus en dit is die gedurige vorming van hierdie selle huis by die een punt in die omtrek van die follikel wat dit moontlik maak vir die follikel om grotendeels in die rigting (van die oppervlakte van die ovarium) uit te sit. Die gedeelte van die follikel wat nie deur die dik meerlagiese wig van thecaselle gedek is nie is omring deur 'n relatiewe dun lagie van die thecaselle. Hierdie thecaselle, soos hulle ouer word, toon later ook vakuolisatie en verander nog later in helder selle wat dan uiteindelik opbrek en verdwyn en ruimte in die wewsel nalaat. Dus is hierdie selle verantwoordelik vir 'n mate van uitsetting van die follikel in sy gehele omtrek, maar die thecaselvorming om dié gedeeltes van die follikel wat nie na die oppervlakte gerig is nie, is lank nie so aktief en aanhouwend soos by die thecaselwig nie en daar is dus baie minder gevakuoliseerde thecaselle om dié gedeelte van die follikel gerangskik. Omrede hierdie kleiner aantal van gevakuoliseerde thecaselle is daar minder disintegrasie van selle en daarom word daar hier minder ruimte vir die follikel vrygestel om in uit te sit as wat die geval is by die basis van die konus van thecaselle. Op hierdie manier word

dit vir die follikel moontlik gemaak om in alle rigtings uit te sit, maar die grootste uitbreiding is altyd in die rigting van die mees aktiewe thecaselvorming en omdat laasgenoemde plaasvind by die thecaselkonus vind die uitbreiding van die follikel hoofsaaklik plaas in die rigting van die oppervlakte van die ovarium.

Dit bly nog altyd 'n vraagstuk wat dan eintlik die stimulus is vir die ontwikkeling van die wig van thecaselle huis oor dié deel van die follikel wat teenoor die naaste oppervlakte van die ovarium geleë is. Dit is baie moontlik dat in gevalle waar ovulasie uitbly en follikelkistes gevorm word daar geen konus gevorm word nie en dat die thecaselle eweredig rondom die hele omtrek van so 'n follikel ontwikkel. So 'n follikel sal dan ewevel in alle rigtings uitbrei en nie net in die rigting van die ovarium se oppervlakte nie. Al word so 'n follikel groter dan normaal kan dit nog gebeur dat dit nooit tot aan die oppervlakte kom nie met die gevolg dat ovulasie nie kan plaasvind nie. Die eweredige ontwikkeling van thecaselle om die follikel en die nie-vorming van 'n thecaselkonus kan moontlik veroorsaak word deur lokale hormonale of bloedvaatstoornisse of deur abnormaliteite of degenerasie van die ovum self. Sulke lokale abnormale reaksies mag ook, behalwe dat hulle die rigting van uitsetting van die follikel verander, die wand van die follikel so verander dat daar 'n vermeerdere transudasie van vloeistof plaasvind in die rigting van die follikelholte en dit kan lei tot 'n abnormalle vergroting van die follikel m.a.w. tot die vorming van 'n follikelkiste.

Die rede waarom daar 'n sterker mate van thecaselontwikkeling is by die deel van die follikel wat teenoor die oppervlakte van die ovarium lê kan miskien gevind word in die embriologiese ontwikkeling van die ovarium. Die kiemselle van die ovarium ontstaan nie uit die oppervlakte epitheel van die ovarium (soos vroeër veronderstel was) nie, maar kom oorspronklik vanaf die dorsale gedeelte van die epithelebekleding van die agterderm. Die kiemselle migrer in hiervandaan tot in die ovarium waar

die meeste dan in die ovariële skors eindig. Sommige dring egter deur tot in die laag oppervlakte-epiteel en hierdie feit het oorsprong gegee aan die foute veronderstelling dat kiemselle deur die oppervlakte-epiteel van die ovarium gevorm word.

In die embrionale ovarium is daar stringe of bande van selle, die sogenoemde Pfluger- of Waldeyer-stringe, wat bestaan uit primordiale eierselle en granulosaselle. Dat hierdie stringe van selle lokaal uit die embrioniese bindweefsel (mesenchym) ontwikkel is reeds aangegetoond deur Fischel.<sup>2</sup> Hierdie stringe van selle vorm die primäre kiemselbande. Sekondäre uitgroeisels vanaf die oppervlakte-epiteel na die primäre bande of stringe is deur Gruenwald<sup>3</sup> beskryf en staan bekend as die sekondäre bande of stringe. Dus staan die kiemselle in die primäre stringe in verbinding met die oppervlakte-epiteel van die ovarium deur middel van die sekondäre Gruenwald-stringe. Ieder follikel ontwikkel uit 'n kiemsel in die primäre string en dus is daar 'n konneksie tussen ieder follikel en die oppervlakte van die ovarium. Hierdie konneksie is die sekondäre band van selle van Gruenwald wat in die embrionale ovarium voorkom. In die volwasse ovarium is hierdie stringe van Gruenwald nie meer duidelik aan te toon nie. Dit is egter moontlik dat op die oorspronklike plek van hierdie Gruenwald-stringe daar nou stromaselle in die ovarium is wat iets verskil van die ander stromaselle. Eersgenoemde stromaselle reageer moontlik gouer en sterker op die prikkel van die granulosaselle en die eisel om tot thecaselle te verander. Omdat die organiserende follikel aan die binneste end van 'n Gruenwald-baan voorkom is die ontwikkeling van thecaselle daar ook progressief vanaf die follikel tot aan die oppervlakte van die ovarium.

Dit is dus moontlik dat die sekondäre stringe van selle wat die embrionale kiemselle met die oppervlakte verbind die uiteindelike baan van thecasel-ontwikkeling determineer en sodoende die follikel altyd in die rigting van die oppervlakte van die ovarium lei in latere follikel-groei.

#### SAMEVATTING EN KONKLUSIES

Die thecasel-verandering wat om follikelkistes plaasvind word beskryf en daar word veral klem gelê op die feit dat vakuolisatie vry algemeen in hierdie selle voor-

kom en dat disintegrasie op totale vakuolisatie van die selle volg. Degenerasie van thecaselle is verantwoordelik vir die ontstaan van die weefselsplete wat om kisteuse follikels voorkom.

Die opvatting dat die 'Strassmann-konus' van thecaselle die ovariumweefsel infiltrer en vernietig en sodoende die follikel 'n kans gee om in die rigting van die oppervlakte uit te sit, is nie bewys nie en is ook baie onwaarskynlik as op die feite gelet word. Die skrywer stel hom die proses as volg voor: Die vorming van groot aantal van gevakuoliseerde thecaselle in die basis van die thecaselkonus het tot gevolg dat wanneer die selle degenereer daar ruimte vrykom vir die follikel om uit te sit in die rigting van die oppervlakte van die ovarium. Daar word steeds nuwe selle gevorm by die punt van die konus en die ouer gevakuoliseerde selle kom dus in die basis van die konus voor. Hierdie selle degenereer en laat 'n spasie oop in die basis van die konus waarin die follikel dan uitsit. Soos die ruimte in die basis van die konus opgeneem word, word die grootte van die konus herstel deur die vorming van nuwe selle aan sy punt. Die konus behou dus sy grootte maar verplaas homself in die rigting van die oppervlakte en dit gebeur nie deurdat die konus die stromaselle vernietig wat tussen hom en die oppervlakte lê nie, maar deurdat dit die stromaselle is wat progressief in die rigting van die oppervlakte tot thecaselle verander. Die enigste selle wat vernietig word (eintlik vanself disintegreer) is die thecaselle in die konus self.

Waar 'n follikel ontwikkel sonder dat daar 'n wig van thecaselle tussen die follikel en die oppervlakte van die ovarium gevorm word, ontstaan 'n kiste en ovulasie vind nie plaas nie.

Ten slotte gee die skrywer 'n moontlike verklaring vir die rede waarom in die normale follikel die Strassmann-konus van thecaselle steeds aan die kant van die follikel teenoor die oppervlakte van die ovarium ontwikkel. Dit is moontlik dat die embrionale Gruenwald-stringe die plek waar die konus later ontwikkel predetermineer.

#### VERWYSINGS

1. Strassmann, E. O. (1938): *Surg., Gynec., Obstet.*, **67**, 299.
2. Fischel, A. (1930): *Z. ges. Anat.*, **92**, 34.
3. Gruenwald, P. (1942): *Amer. J. Anat.*, **70**, 359.

## CONICAL CORNEA IN IDENTICAL TWINS

S. ETZINE

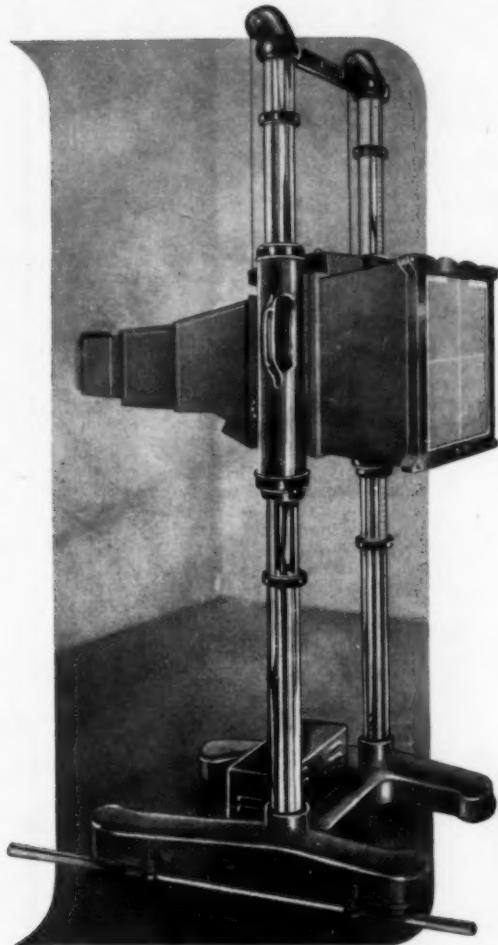
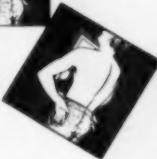
*General Hospital, Johannesburg*

Conical cornea, or keratoconus, is an interesting condition characterized by a cone-shaped ectasia of the central portion of the cornea. It was first reported by Duddel in 1736, and the first description of cases occurring in several members of the same family was that of Von Ammon in 1828. Since that time over 40 families having 2 or more members affected by the disease have been described. However, the occurrence of keratoconus in identical twins does not appear to have been

reported in the medical literature. Dr. Jean Rumpf<sup>1</sup> in his thesis on the heredity of keratoconus summarized the cases reported as having a familial incidence up to 1937, and the present writer has searched through the later literature on keratoconus, without finding a report of its occurrence in twins. As the pathogenesis of the condition is still obscure it is perhaps worth while to report the present cases.



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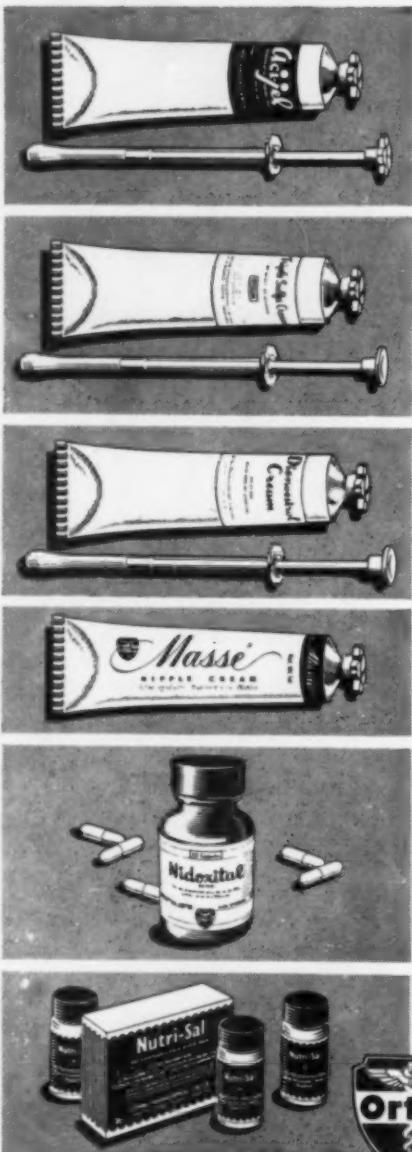
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## CASE REPORTS

**Case 1.** Miss S. du P., aged 19, a female of European descent, consulted me on 3 June 1950 because someone had flicked a piece of orange peel in her right eye. No lesion due to the foreign body was seen. Retinoscopy showed a swirling shadow occupying the central part of the red reflex on the right. The points of neutralization could not be determined. The left eye showed a mixed astigmatism. The readings on the Javal-Schiottz keratometer were as follows:

Right Eye:	45½	dioptres axis	35°
	52½	" "	125°
Left Eye:	46	" "	150°
	48½	" "	60°

The visual acuity was as follows:

Right Eye:	Unaided:	Counts fingers at 1 metre.
		with -5.0 dioptre cylinder axis 35°: 6/36.
Left Eye:	Unaided:	6/24 part.
		with -0.50 sph/-2.0 cyl. axis 150°: 6/6.

A diagnosis of keratoconus on the right was made. The patient reported back on 22 July 1952, when it was found that the axis of astigmatism had changed in the right eye to 25° and in the left eye to 180°. The best corrected visual acuity was now 6/36 on the right and 6/24 on the left.

Both corneas now appeared conical. Superficial opacities were present in the apical zones of the corneas and these areas appeared thin on slit-lamp examination. The reflections of the mires of the keratometer were distorted on both sides. As the patient was not able to carry on her work with the low visual acuity obtainable with spectacle lenses she was fitted with contact lenses. These improved the visual acuity to 6/9 on both sides. Examination in November 1953 showed that this standard of vision had been maintained.

**Case 2.** Miss J. du P. consulted me on 25 August 1953 on account of defective vision. Her face seemed familiar and questioning elicited the information that she and Miss S. du P. were identical twins. Although the unaided visual acuity proved to be less than 6/60 on both sides she had never previously consulted

anyone about her eyesight. Examination revealed a fully developed keratoconus on the right and an early keratoconus on the left. Retinoscopy showed an oil-globule effect on the right. Slight superficial corneal opacities were present in the right eye. Both sides showed distortion of the mires of the keratometer. The keratometer readings were as follows:

Right Eye:	58½	dioptres axis	20°
	52½	" "	110°
Left Eye:	47½	" "	160°

51 " " 70°

The visual acuity could not be improved with lenses above counting fingers at 1 metre on the right. On the left the visual acuity with spectacle lenses was 6/18.

## DISCUSSION

It may be noted that in both patients the keratoconus was more marked on the right side. No associated abnormalities, such as retinitis pigmentosa, were present. Consanguinity of the parents was denied. It is regretted that it was not found possible to examine other members of the family for either overt forms or *formes frustes* of conical cornea.

## SUMMARY

The occurrence of keratoconus in a pair of identical twins is described.

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L. M. MARCHAND  
Associate Secretary

Medical House  
35 Wale Street  
Cape Town  
5 February 1954

L. M. MARCHAND  
Medesekretaris

Mediese Huis  
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Dr. J. M. Symington .....	10 6	Dr. J. R. van Heerden .....	-
Dr. H. L. Cohen .....	1 11 6	Dr. D. G. Cowie .....	-
Dr. W. L. Jenkinson .....	10 -	Dr. J. P. Grieve .....	-
Prof. E. C. Crichton .....	10 -	Dr. H. H. Stormans .....	-
Dr. J. P. Immelman .....	11 -	Dr. A. L. van der Merwe .....	-
Dr. F. P. Luke .....	10 6	Dr. J. D. Napier .....	-
Dr. P. D. Nel .....	1 -	Dr. R. B. Peckham .....	-
Dr. E. H. Boodrie .....	1 -	Dr. M. H. Campbell .....	-
Dr. C. Ackerman .....	1 -	Dr. A. L. Young .....	-
Dr. J. T. Braude .....	1 -	Dr. R. Burns .....	1 -
Dr. F. L. Potter .....	1 -	Dr. F. S. Drewe .....	1 -
Dr. J. N. Sher .....	1 -	Dr. E. R. Hafner .....	1 -
Dr. S. Shapiro .....	1 -	Dr. I. Goldberg .....	1 -
Dr. J. Walker .....	1 -	Dr. G. D. Morgan .....	1 -
Dr. C. C. Brown .....	1 -	Dr. W. J. Naude .....	1 11 6
Dr. J. S. Norwell .....	1 -	Dr. H. W. Needham .....	10 6
Dr. I. Friedman .....	1 1 -	Dr. A. R. Bain .....	1 1 -
Dr. A. H. Blyth .....	5 -	Dr. F. E. Bamford .....	1 1 -
Dr. M. Eliot .....	1 -	Dr. L. M. Cohen .....	1 -
Dr. C. S. A. O'Molony .....	6 6	Dr. T. H. Whitsitt .....	1 -
Dr. N. B. H. Veldman .....	1 1 -	Dr. J. C. U. Ehlers .....	1 -
Dr. H. P. G. Militz .....	1 1 -	Dr. E. G. Hestines .....	1 -
Dr. P. D. Kidd .....	1 1 -	Dr. S. S. Hoffman .....	1 1 -
Dr. K. Strauss .....	1 1 -	Dr. J. R. Reznek .....	1 1 -
Dr. S. H. Cohen .....	1 1 -	Dr. N. A. van Buuren .....	1 -
Dr. G. W. Huggens .....	1 1 -	Dr. H. A. Hahn .....	1 -
Dr. N. L. Murray .....	1 -	Dr. B. P. Friedland .....	10 6
Dr. H. Penn .....	10 -	Total .....	£177 7 6
Dr. J. G. Landsberg .....	2 2 -		
Dr. G. G. Henderson .....	1 1 -		

## DR. H. A. MOFFAT MEMORIAL FUND

The following contributions to the Dr. H. A. Moffat Memorial Fund during November and December 1953 and January 1954 are gratefully acknowledged:

	£ s. d.		£ s. d.
Dr. R. F. Denholm, Benoni .....	10 10 -	Dr. J. Selkon, Cape Town, per Dr. Jack Abelsohn	1 1 -
Dr. Morris Helman, Sea Point .....	3 3 -	Dr. A. Schiller, Cape Town, per Dr. Jack Abelsohn	1 1 -
Dr. J. C. Coetzee, Cape Town .....	3 - -	Dr. Ruby Sharp, Cape Town, per Dr. Jack Abelsohn	2 2 -
Dr. S. Berman, Cape Town .....	2 2 -	Dr. Jerome Rabkin, Cape Town, per Dr. Jack	
Dr. E. M. Broome, Cape Town .....	2 2 -	Abelsohn .....	1 1 -
Dr. M. A. Pringle, Johannesburg .....	1 1 -	Dr. B. Porter, Cape Town, per Dr. Jack Abelsohn	1 1 -
Dr. Basil L. Goldschmidt (Overseas) .....	1 1 -	Dr. H. Wykard, Cape Town, per Dr. Jack Abelsohn	1 1 -
		Dr. T. Shadick Higgins, Cape Town .....	5 - -
			£35 6 -

## MOTOR ACCIDENT PATIENTS IN HOSPITAL

The following letter has been addressed to the Secretary of the Medical Association of South Africa by the Provincial Administration of the Cape of Good Hope:  
*Motor Vehicle Insurance Act, 1942*

24 November, 1953.

Sir.—With reference to the discussion which representatives of your Association had on 18 June 1953, with officials of this Department regarding difficulties experienced in recovering fees for medical treatment in respect of patients admitted to provincial hospitals as a result of motor accidents, I have to state that if any medical practitioner is in doubt as to whether or not a case falls under the Motor Vehicle Insurance Act, 1942, he may ascertain from

the Medical Superintendent whether compensation is payable in terms of the Act and whether hospital fees are being paid.

I may add that this Department does not see its way clear to place the responsibility of informing private medical practitioners of all cases in respect of which hospital fees are paid or likely to be paid, upon Medical Superintendents of provincial hospitals, but as stated above, would have no objection to private practitioners approaching them for information.

I am, Sir,  
 Your obedient servant,  
 (signed) H. Bosman,  
 for Director of Hospital Services

## IN MEMORIAM

### WILFRED SHAW

M.A., M.D. Camb., F.R.C.S., F.R.C.O.G.

Mr. Wilfred Shaw, surgeon in charge of the Gynaecological and Obstetrical Department at St. Bartholomew's Hospital, died in London on 9 December 1953 on the eve of his 56th birthday. His untimely death after a long and lingering illness will be mourned by hundreds of Barts men all over the world whom he taught during the past 30 years. His speciality has lost one of its most original and vigorous minds.

He was born in Birmingham on 12 December 1897 and was educated in that city and at St. John's College, Cambridge. There he had a brilliant student career, which he continued at Barts by winning the Matthews Duncan prize and gold medal, the Lawrence Research prize and gold medal, and the Cattlin research scholarship. He qualified in 1921, was admitted F.R.C.S. in 1923, proceeded to the M.D. in 1928, and was elected F.R.C.O.G. as a founder member in 1932.

During World War I he interrupted his studies to serve with the Navy as a surgeon-probationer, mostly in destroyers. After completing his house-appointments at Barts he went to Vienna, where he worked with Professor Amreich and Walter Schiller, under whose influence Wilfred Shaw was to further his meticulous scientific work in the laboratory as well as in the operating theatre. The work he did after his return, particularly on the then new concept of ovarian-endometrial relationships, and on the pathology of ovarian tumours, was to bring him rapidly to the forefront of British gynaecologists.

In 1926 he became the first incumbent of the new post of resident assistant physician-accoucheur at Barts and, in 1931, he was elected to the honorary staff at Barts, and became head of his department in 1946. He was a gifted and brilliant teacher and very soon his Text-book of Gynaecology was published. This was to reach its sixth edition in 1952. He always insisted that it was inspired by, and intended for, his own students. When it first appeared he caused to be placed a note-book in his old O.P.D. at Barts, in which students were invited to write their criticisms, comments and suggestions about the new text-book. These were frequently pungent in the manner known only to medical students; but when



Wilfred Shaw

the next edition appeared he acknowledged suggestions by name.

He was an examiner for the Conjoint Board, London University, and Oxford and Cambridge finals, as well as for the Royal College of Obstetricians and Gynaecologists. He was sensitive and kindly and disliked examining, reacting always with gentleness and generosity towards the timid and harassed student.

During World War II, exiled in Wiltshire in charge of a midwifery centre, he completed his Text-book of midwifery, now in its third edition.

It was typical of the man that he should spend his last two years, already in the shadow of death, writing a text-book of gynaecological surgery, which he completed only a few weeks before the end.

Wilfred Shaw brought to his clinical gynaecology the mind and outlook of a pathologist. He insisted that the entry to his speciality was through the discipline of the laboratory, and the lens of the microscope. He was a brilliant gynaecological pathologist and loved nothing more than a session over some slides; and it was ever a joy to discuss a knotty problem with him and note the breadth and sweep of his mind.

At the Williamson Laboratory at Barts (uniquely devoted to gynaecological pathology) he established a superb collection of specimens and slides, many of which, in his early days, he cut and stained himself, between deliveries. It was in this little laboratory that the writer served as 'path. clerk' under him and was privileged to collaborate in research projects of which the vision and perception were proven with the unfolding knowledge of succeeding years.

His O.P. classes, his lectures and his rounds were unforgettable and, as John Howkins wrote of him the other day, 'though his students came to learn gynaecology, they achieved more than this simple object. Elizabethan poetry and drama, higher mathematics, nuclear physics, international politics, the history of Barts, all came within the syllabus. His memory was prodigious. He knew the name of every Barts student, his history, his wife's name and the number and names of their children, whom he had probably delivered himself.'

Wilfred—it was impossible for those who knew him to think of him by any other name—was an inspiring teacher and a devoted friend and colleague. There are many men in all fields who owe

much to his sound wisdom and shrewd advice, usually given with a gay twinkle in his eye and a sardonic shaft.

His interest in his old students never waned. In correspondence, which continued for 15 years, he was ever inquiring after the doings and welfare of the many Barts men in South Africa, a country which possesses more of them than any outside Britain. To have worked at his side and known him intimately was an enriching human and intellectual experience.

Without him Barts will never be quite the same again, and many who gather daily in the Square will miss the figure at the Fountain, standing in characteristic posture, hands clasped behind his back, chin hunched down on his chest, greeting passers-by with characteristic grimace and darting smile as he waited for his Round to assemble.

Mr. Shaw leaves a widow, three sons and a daughter, to whom we extend our sincerest sympathies.

#### SHORT TITLES FOR MEDICAL DEGREES

The University of Cape Town has issued a list of degrees in the Faculty of Medicine with their official short titles which includes the following:

Bachelor of Medicine and Bachelor of Surgery, M.B., Ch.B.  
Master of Medicine, Medicine: M.Med.  
Master of Medicine, Paediatrics: M.Med. (Paed.).  
Master of Medicine, Dermatology: M.Med. (Derm.).  
Master of Medicine, Radiodiagnosis: M.Med. (Rad. D.).

Master of Medicine, Radiotherapy: M.Med. (Rad. T.).  
Master of Medicine, Pathology: M.Med. (Path.).  
Master of Medicine, Anaesthetics: M.Med. (Anaes.).  
Master of Surgery, Surgery: Ch.M.  
Master of Surgery, Orthopaedics: Ch.M. (Orth.).  
Master of Surgery, Otorhinolaryngology: Ch.M. (Otol.).  
Master of Surgery, Ophthalmology: Ch.M. (Ophth.).  
Master of Obstetrics and Gynaecology: M.O. & G.  
Doctor of Medicine: M.D.

#### PASSING EVENTS : IN DIE VERBYGAAN

The latest list of accessions to the Medical Library is available at present. Members of the Medical Association who wish to obtain a copy may do so upon application to the Medical Librarian, Medical Library, Anzio Road, Mowbray, C.P.

#### CONGRESS OF OPHTHALMOLOGY

The Seventeenth International Congress of Ophthalmology will be held in Montreal, Canada, from 9 to 11 September and in New York from 12 to 17 September 1954. Enrolment of members should reach the President Mr. M. R. Marshall not later than 27 February and should be addressed to Wells Pavilion, University Hospital, Edmonton, Alberta, Canada.

#### RECOGNIZED TERMS FOR SPECIALITIES

Members are reminded that only terms recognized by the South African Medical and Dental Council for the registration of their specialities may be used in describing their forms of practice. Other terms, for example, 'cardiologist', are not allowed.

Similarly, persons who have held Chairs in University Faculties are not allowed to use the title 'Professor' if they enter private practice.

#### FOOD, DRUGS AND DISINFECTANTS ACT, 1929

In the *Government Gazette* of 5 February 1954 the Minister of Health publishes for general information:

1. Draft Regulations (Government Notice No. 179) concerning the composition, etc., of milk; pasteurized or sterilized milk; skim-milk or separated milk; flavoured skim-milk; or flavoured separated milk; dried milk, powdered milk or milk powder; dried skim-milk or dried separated milk, skim-milk powder or powdered skim-milk; unsweetened condensed, evaporated or concentrated milk; sweetened condensed, evaporated or concentrated milk; unsweetened condensed, evaporated or concentrated skim or separated milk; sweetened condensed, evaporated or concentrated skim or separated milk; malted milk powder or powdered malted milk; buttermilk; and cultured milk.

2. Draft Regulations (Government Notice No. 180) concerning the composition etc., of jam, including preserves and conserves; marmalade; fruit-jelly; jelly crystals or 'Table Jellies'; canned fruits; canned fruit juices; canned vegetables or canned vegetables with meat; canned spaghetti; canned soups; and other canned food products.

Interested persons are invited to submit criticism of the above draft regulations to the Secretary for Health, P.O. Box 386, Pretoria, before 5 May 1954.

#### COMMONWEALTH HEALTH AND TUBERCULOSIS CONFERENCE, LONDON

The National Association for the Prevention of Tuberculosis is holding the Fourth Commonwealth Health and Tuberculosis

Conference at the Royal Festival Hall, London, on 21-25 June 1955. The Conference will include lectures, demonstrations and clinical meetings on the first 3 days, and practical demonstrations and visits to sanatoria, hospitals and clinics on the last 2 days. There will be a trade exhibition including X-ray apparatus, medical equipment, pharmaceutical products and medical and technical books; a scientific exhibition covering a wide field of research and clinical demonstrations; and an exhibition of art therapy and occupational therapy including displays of patients' handicrafts. Cinema film demonstrations will also be arranged.

The conference fee is £4 4s. for 4 days or 30s. for a single day or session. Messrs. Thomas Cook and Son, Limited, and C.I.E. Int. des Wagons-lits are acting as travel agents for the Conference. Further particulars are obtainable from the Secretary-General, NAPT, Tavistock House North, Tavistock Square, London, W.C.1., England.

#### FELLOWSHIPS OFFERED

Applications are invited by the Council of the Royal Society for two Stothert Research Fellowships and one Alan Johnston, Lawrence and Moseley Research Fellowship.

The Stothert Fellowships are awarded in the field of medicine, including the sciences on which medical knowledge is based, and are tenable at any hospital in the British Isles or at any other place approved by the Council of the Royal Society.

The Alan Johnston, Lawrence and Moseley Research Fellowship is awarded for research into the problems of human and animal health and diseases and the biological field related thereto. It is tenable at any place approved by the Council of the Royal Society.

Candidates should supply the usual personal details and give the names of two referees. Testimonials will not be considered. Applicants and referees at a distance may write direct to the address given below, without first obtaining forms. The subject of the proposed research and the place at which it would be carried out, together with the name of the Head of the Department, should be given.

The appointments will be for two years in the first instance from 1 October 1954, and will be subject to conditions governing Royal Society Research appointments. The stipend for the Stothert Fellowships will be £600 per annum renewable annually up to a total of four years with annual increments of £50 per annum. The stipend for the Alan Johnston, Lawrence and Moseley Research Fellowship will be £1,000 per annum renewable up to a total of five years with annual increments of £75 per annum.

Applications should be made on forms to be obtained from the Assistant Secretary, The Royal Society, Burlington House, London, W.1, and should be received as early as possible, in any case not later than 30 April 1954.



\* Kodak is a registered trade-mark

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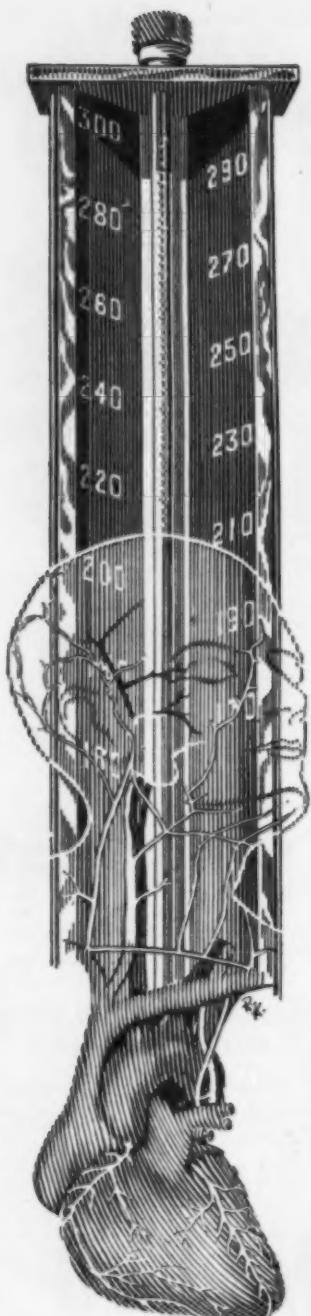
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*In Cardiology***'Hyperysin'**

HOMMEL

*for rapid and safe  
antihypertensive effect*

In the treatment of all manifestations of vascular spasm, it is now believed that papaverine nitrite has superseded the hydrochloride because of the latter's greater toxicity. Furthermore, the classically recognized value of nitrates in hypertension and the accepted sedative efficacy of papaverine are happily combined in the potentiated antispasmodic action of papaverine nitrite — the principal ingredient of 'Hyperysin.'

**COMPOSITION**

'Hyperysin' tablets each contain:

Papaverine nitrite .. .. .. ..	0.7 gr. approx.
Hexamethylenetetraminodichloralhydrate .. ..	3.0 gr. approx.
Carbromalum B.P.C. .. .. .. ..	3.0 gr. approx.

**ADVANTAGES****Low toxicity:** Papaverine nitrite is less toxic than papaverine.**Synergism:** The papaverine nitrite is synergistically potentiated by two other reputable sedatives.**Gradual effect:** 'Hyperysin' does not act so abruptly as the majority of nitrates.**INDICATIONS**

'Hyperysin' is a clinically proven agent in cardiovascular diseases manifesting arterial spasm and pathologically raised B.P.

***Essential Hypertension******Angina Pectoris******Angiospastic Crises******Intermittent Claudication*****PACKING:** Containers of 15 and 500 Tablets.**HOMMEL'S HÆMATOGEN & DRUG CO.**

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## LECTURES BY PROFESSOR BRADLEY M. PATTEN

Professor Bradley M. Patten of the Anatomy Department of the University of Michigan Medical School, accompanied by his wife, is visiting South Africa on his way to New Zealand, where he has been appointed as Visiting Professor at the University of Otago in Dunedin. He has specially broken his journey to spend 5 weeks in the Union.

Professor Patten has delivered a series of lectures at the University of the Witwatersrand on the development and congenital anomalies of the heart, on which subject he is a world authority. He will be in Cape Town from 23 February to 4 March. During this period he will deliver 5 lectures at the Anatomy Department of the University of Cape Town Medical School:

- (1) A moving-picture study of the first heart beats and the beginning of the embryonic circulation.
- (2) Changes in the location of the pacemaker and the correlated changes in the electrocardiographic pattern of the embryonic heart (illustrated by micromoving pictures and lantern slides).
- (3) The partitioning of the heart.
- (4) The prenatal intracardiac balance and the changes in circulation following birth.
- (5) Congenital defects of the heart.

In Cape Town the lectures will be arranged for the evenings, when all medical practitioners are invited to attend. The dates of the lectures will be posted at the respective Medical Schools.

In Johannesburg Professor and Mrs. Patten were the guests of the Principal of the University of the Witwatersrand; while in Cape Town they will stay with Dr. R. Singer of the Anatomy Department.

## CONGRESS OF OCCUPATIONAL THERAPISTS

The World Federation of Occupational Therapists will hold an International Congress on 16-21 August 1954 in Edinburgh, Scotland. The Federation is anxious to have speakers from different countries on the subjects of tuberculosis, plastic surgery, poliomyelitis, cerebral palsy and psychiatry. Any members interested in these subjects who may be in Europe at that time are requested to communicate with the Organizing Secretary, at the Astley Ainslie Hospital, Edinburgh.

## UNION DEPARTMENT OF HEALTH BULLETIN

Report for the seven days ended Thursday 4 February 1954.  
*Plague, Smallpox. Nil.*

*Typhus Fever. Cape Province.*

One (1) Native case in the Queenstown municipal area. Diagnosis confirmed by laboratory tests. Three (3) Native cases and one (1) Native death in the Ntlatbeni location in the Mount Frere district. Diagnosis based on clinical grounds only.

*Epidemic Diseases in other Countries.**Plague. Nil.*

*Cholera in Dacca (Pakistan), Calcutta, Madras, Nagapattinam, Tiruchirappalli, Visakhapatnam (India).*

*Smallpox in Lahore, Chittagong (Pakistan), Allahabad, Bombay, Calcutta, Cochin, Delhi, Jodhpur, Kanpur, Madras (India), Haiphong, Hanoi, Saigon-Cholon (Viet-Nam).*

*Typhus Fever. Nil.*

## NEW PREPARATIONS AND APPLIANCES

'Rauwiloid': 'Rauwiloid' presents a new approach to the treatment of hypertension. The claim is made that by itself or combined with 'Veriloid'<sup>1, 2</sup> it is the only effective hypotensor which is at the same time absolutely safe; that neither drug has ever caused a fatality or serious collapse; and that even in heavy overdosage Rauwiloid remains safe. Clinical studies show that the hypotensive action of Rauwiloid is of moderate intensity, and it will therefore find its greatest usefulness in mild to moderate cases of hypertension.

Rauwiloid is an alkaloidal extract developed by Riker Laboratories, of Los Angeles. It represents the optimum hypotensor effect of the plant *Rauwolfia serpentina* in reproducible, physiologically-standardized form. Further purification of the alkaloidal mixture has been found to sacrifice part of the hypotensive action with no compensating gains on other scores.

Rauwiloid does not produce excessive hypotension, and it is of interest to note that its effect is cumulative to a given desirable point, analogous to the process of digitalization.

Coincidentally with its hypotensive effect, Rauwiloid counteracts tachycardia by a bradycardic action associated with increased heart output. These effects are accompanied by marked subjective improvement, represented by a feeling of well-being, tranquillity without drowsiness, and an increase in energy.

Rauwiloid combined with Veriloid is indicated in a large majority of hypertensive patients, particularly in chronic, severe, fixed or resistant types. In this form the patient is able to tolerate larger doses of Veriloid than when this alkaloidal extract is given alone, if increased dosage is desirable. The two drugs appear to be mutually potentiating, as the summation of their effect is often greater than would be expected from them separately.

## NUWE PREPARATE EN TOESTELLE

There are no contra-indications and side-effects are mild and rare.<sup>3</sup>

Stocks may be obtained from Riker Laboratories Africa (Pty.), Ltd., P.O. Box 1355, Port Elizabeth, through the usual trade channels.

1. Registered Trade Mark.
2. S. Afr. Med. J., 1953, 27, 191.
3. Literature available from the manufacturers, P.O. Box 1355, Port Elizabeth.

'Nivembin'. Maybaker (S.A.) (Pty.), Ltd., of Port Elizabeth supply the Nivembin brand chloroquine/diiodohydroxyquinoline association in tablet form, each tablet containing 65 mg. chloroquine sulphate (equivalent to 50 mg. chloroquine base) with 300 mg. of diiodohydroxyquinoline.

This preparation, they state, constitutes a complete medical treatment for uncomplicated amoebiasis, irrespective of whether the predominant clinical manifestations of the case are hepatic or intestinal. For most cases a course of treatment lasting 1-3 weeks is sufficient to eradicate the parasites.

Nivembin is also used in the combined prophylaxis of amoebiasis and malaria for short-term visitors to endemic areas of these diseases.

The firm state that daily prophylaxis will prevent acute malaria and prevent or counteract the early intestinal disturbances which follow ingestion of the encysted Endamoeba.

## BOOK REVIEWS :

## HISTORY OF MEDICINE IN OXFORD

*Medicine in Oxford. A Historical Romance.* By Maurice Davidson, M. A., D.M. (Pp. 70 with illustrations. 10s. 6d.) London: Macmillan & Co. Ltd. 1953.

Contents: Lecture 1. From the Origin of the University to the end of the Thirteenth Century. 2. From the Beginning of the Fourteenth Century to the Laudian Code (1636). 3. From the Laudian Code (1636) to the Early Nineteenth Century. 4. From the Early Nineteenth Century to 1914 A. D. Epilogue. Bibliography.

The eminent British neurologist, F. M. R. Walshe, recently pleaded the cause of the arts in medicine: a bridge must be reconstructed

## BOEKRESENSIES

between medicine and the humanities, and it can only be done from the side of medicine, he said. This book, whose chapters constitute the Fitzpatrick Lectures delivered before the Royal College of Physicians last year by an equally celebrated Fellow, has Dr. Walshe's dictum as its *leit-motif*. In tracing the history of medicine in that, 'the most noble emporium of all good sciences', Dr. Davidson makes a scholarly contribution to the post-war trend in British medicine to take stock of its past.

While the author traces the history of Oxford medicine from the distant mist of pre-Chaucerian times and there are illustrious names enough to people his chronicle up to the middle of the nineteenth

century, he only thinly disguises his nostalgia for the Oxford of Acland, the great champion of the natural sciences a hundred years ago. Led here by a coterie of famous men, medicine was divested of her medieval garb, and brand-new tenets were propounded which shook the grey towers of the old university town; for it was the age of Dr. Pusey and his Tractarians, of Charles Darwin, and the decade in which the Bishop of Oxford asked Dr. Huxley which of his grandparents was descended from a monkey.

Dr. Davidson is the author of a standard text-book on chest diseases and he has written a monograph on bronchial carcinoma: this, we are told, is his *debut* into the non-professional field. If only for his erudition and polished style he would deserve sincere commendation for this little book; but he also makes a substantial contribution in stones and mortar to the bridge of Dr. Walshe. Perhaps, too, it is a significant pointer to the future pattern of medical education that one of the foremost technologists of our age should decry the supremacy of technology at the expense of the arts, and testify by experience to the professional value of his own grounding in the humanities.

E.H.B.

#### FOOD POISONING AND FOOD HYGIENE

*Food Poisoning and Food Hygiene*. By Betty C. Hobbs, B.Sc., Ph.D., Dip. Bact. (Pp. 174 + ix, with 44 illustrations. 14s.) London: Edward Arnold & Company. 1953.

*Contents:* Part I. Food Poisoning and Food-borne Infection. 1. Introduction. 2. Elementary Bacteriology. 3. Bacterial Causes of Food Poisoning. 4. Human and Animal Reservoirs of Infection and Ways of Spread of Infection. 5. The Vehicle of Infection. 6. Examples of Outbreaks of Food Poisoning. 7. Food-borne Infection. Part II. Food Hygiene in the Prevention of Food Poisoning. 8. Introduction. 9. Personal Hygiene of the Food-Handler. 10. Food Storage and Preparation. 11. Utensil Cleaning and Sterilization. 12. Kitchen Design and Equipment. 13. Control of Vermin. 14. Food Trader's Part. 15. Legislation—Present and Future. 16. Education. Index.

This little book of 170 pages has been primarily written for those individuals concerned with the food distribution and catering trade. Its style is easy and the terminology is simple and should be easily understood by members of the public who have little or no medical or bacteriological knowledge.

It should also be found most useful by health officers, health inspectors and teachers of Domestic Science at technical colleges and at schools.

The chapters on kitchen equipment are well set out and the photographs throughout the book are self-explanatory. A useful index completes this little manual.

This book can be highly recommended to all concerned with the handling, preparation and control of foodstuffs.

E.D.C.

#### Study of ILLNESS IN TWINS

*Psychotic and Neurotic Illnesses in Twins*. Medical Research Council Special Report Series, No. 278. By Eliot Slater and James Shields. (Pp. 385 + v. 21s. 0d.) London: Her Majesty's Stationery Office, 1953.

*Contents:* I. Twin Investigations in Psychiatry. 1. History. 2. Rationale. 3. Validity. 4. Previous Work on Unselected Series of Psychiatric Twins. II. The Present Investigation: General. 1. Planning. 2. Sex and Ovularity Distribution of Twin Pairs. 3. Finger-prints. 4. Incidence of Twinning in Relatives of Twins. 5. Birth Order of Twin Pairs. 6. Clinical Diagnosis of Propositi. 7. Size of Family. 8. Abnormality in Family. 9. Personality Resemblance Between Uniovular Twins. 10. Twins Separated in Childhood and Later Life. 11. Factors Predisposing to, or Associated With, Mental Illness. III. The Present Investigation: Clinical. 1. The Schizophrenic Twins. 2. The Affective Twins. 3. The Twins with Organic States. 4. The Psychopathic and Neurotic Twins. 5. Abnormal Personalities in the Four Clinical Groups. IV. Summary and Conclusions. References. Appendices. V. Case Material.

#### CORRESPONDENCE

##### PROPOSED SOUTH AFRICAN CARDIAC SOCIETY

To the Editor: Correspondence has been taking place for some months between the President and Secretary of the British Cardiac Society and ourselves on the formation of the South African Cardiac Society.

As the British Cardiac Society has no branches outside Great Britain they have suggested to and encouraged us to form an independent Cardiac Society.

In the field of human behaviour no riddle looms larger than the ancient one: What, in the formation of personality, are the relative contributions of environment and heredity? Until we can define nicely the influence exerted by each many of the current pre-occupations of psychiatrist, sociologist, jurist and moralist must continue somewhat blind. It remains extraordinarily difficult to find valid means of tracing genetic influences so as to determine to what extent man's nature is unchangably endowed at his conception.

The great Freud himself, with fine realism, could but wave aside the inborn constitutional forces (while conceding wholeheartedly their huge significance) and announce that he would devote his attention selectively to the effect exerted by life experiences upon the developing individual.

It was Galton who perceived how much could be learnt of the genetic constituents of personality through study of twins, uniovular (identical) and binovular (dissimilar); when differences in personality are present between two members of an identical twin pair it is the environment which has induced the difference. Since Galton's time criteria for study have been sharpened; at Dr. Slater's disposal to fix whether a twin is indeed identical are the refinements of photography, hand- and foot-prints, blood-groups, hair- and eye-colour, and brain wave patterns; the authors have classified their case material impeccably.

Dr. Slater's earlier researches now culminate in this authoritative monograph, which traces by means of twin studies the importance of inherited constitution in the causation of mental illness. The authors have collected a total of 297 twin pairs for statistical analysis. The resulting report is scholarly, significant and fascinating, confirming that no student of personality can overlook the genetic, inborn determinants of behaviour.

Not everybody will be equally satisfied that this investigation defines these determinants distinctly or with any finality, or that in obtaining the life-histories the emotional responses of the subjects have been probed enough. But there will be no dissent that the authors have done excellently work which contributes to the imposition of scientific order upon the rich chaos of present-day psychiatry.

It seems of inescapable significance that 76% of the uniovular twins of schizophrenics had schizophrenic illnesses. As important to Dr. Slater appears the finding that among binovular (dissimilar) twins, the twin who in adult life shows the gravest mental illness, during childhood also had the more marked neurotic symptoms. (Identical twins do not differ in this way: the one is not neurotic if the other is balanced, it appears.)

On the basis of this finding Dr. Slater rejects the view that the neurotic patterns occurring in childhood are environmentally produced—as psychoanalysis holds. His figures suggest rather that the constitution predisposing to neurosis in childhood, and to psychotic illness in later life, is genetically determined.

Such evidence must be given due weight. The authors' conclusions are just and, in their context, valid. Elsewhere Dr. Slater has stated the meaninglessness of a purely static concept, even from a genetical point of view. Constitution itself must be a dynamic concept, unfolding in time as latent genes become manifest and environmental influences work upon the individual.

In the present work it is remarked that the discordant uniovular twin pairs strengthen the impression that environmental factors play a large part in disorders of behaviour. Nature and nurture combine to affect the personality, and it seems—even with the neat scientific tool of twin study—their relative contributions to the individual life-history can seldom be untangled.

H.W.

#### : BRIEWERUBRIEK

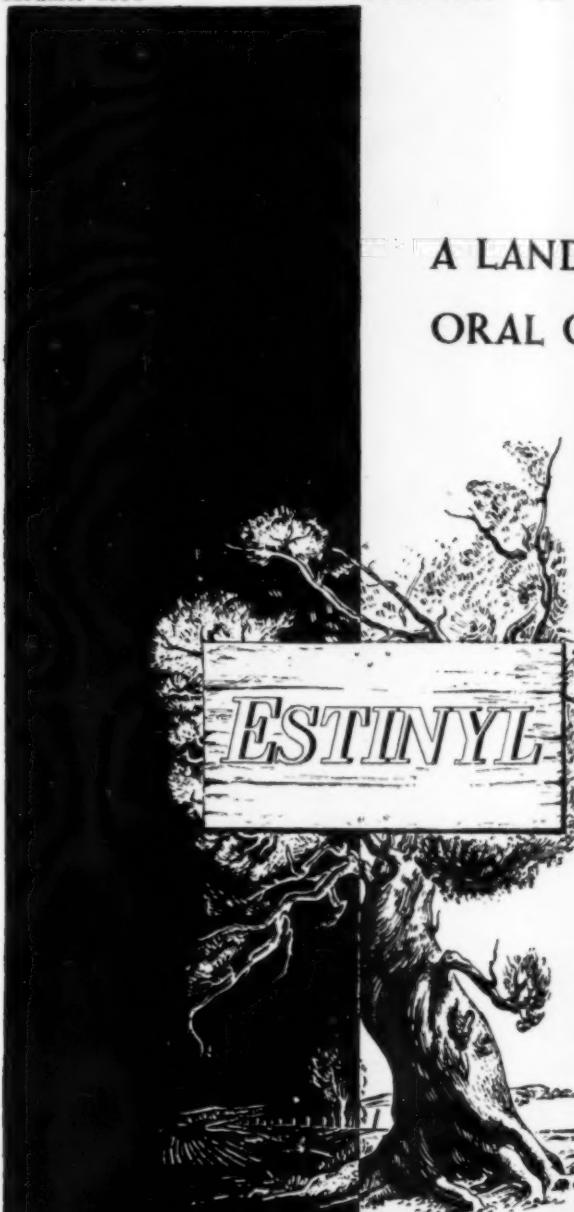
The President and Council have sent us a copy of their constitution and rules, on which we are modelling the South African Cardiac Society.

Would anyone who is interested please write to us? We shall be only too glad to send a draft copy of the constitution and rule.

Cardiac Clinic  
Groote Schuur Hospital  
Observatory, Cape  
4 February 1954

Maurice Nellen  
V. Schrire  
L. Vogelpoel

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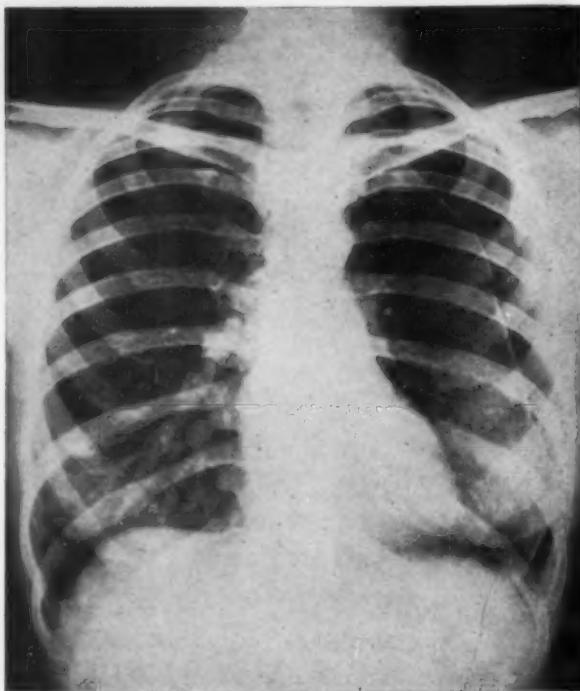
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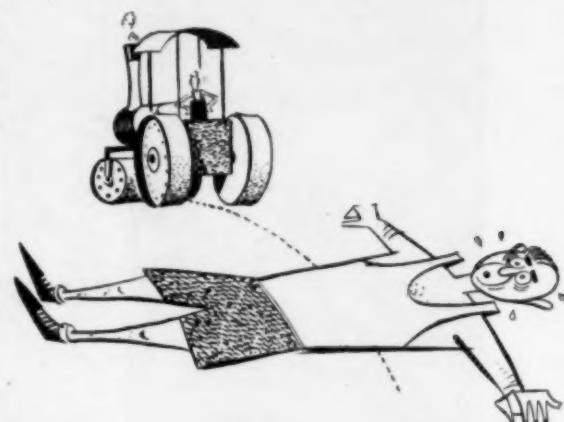
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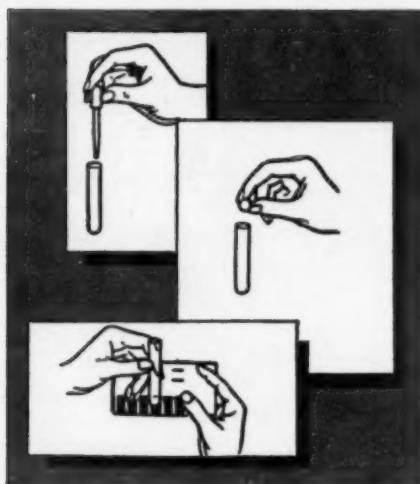
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## Die Mediese Vereniging van Suid-Afrika The Medical Association of South Africa

AGENCY DEPARTMENT : AGENTS KAP-AFDELING

KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177: P.O. Box 643, Telephone 2-6177

#### PRAKTYKE TE KOOP : PRACTICES FOR SALE

(1280) Ciskei rural practice. Gross receipts £3,151. Premium required £1,500 including instruments, large stock of drugs, fittings and furniture. Terms available. Knowledge of Native language not essential.

(1399) Transkei. Unopposed prescribing practice. Cash receipts 1950/51/52—£3,887 18s. 10d., £4,814 2s., £5,064 5s. 6d. Two appointments. Practically no night work. Premium required £2,200. Large house for sale at £2,300. Jeep also offered for sale. Terms possible.

(1436) Goedgevestigde Karoo-praktyk. Ontvangste ongeveer £3,000 p.j. D.S. en M.O.H. aanstellings. Koopprys £1,500 wat voorrade insluit. Gerieflike woning met spreekkamers beskikbaar teen besonder billike huurgeld.

(1487) Plattelandse praktyk sonder opposisie geleë in mooi omgewing. Kontantontvangste ± £2,400. Koopprys van £1,250 sluit klandisiwaarde, alle geneesmiddels, instrumente en meubels in. Paaiente aanvaarbaar. Goeie woonhuis en spreekkamers te huur teen £7 10s. p.m. DIT IS 'N UITSTEKENDE GELEENTHEID OM 'N GOEIE PRAKTYK IN 'N MOOI OMGEWING TE BEKOM.

(1596) Kaapse Middellande, Hospitaaldorp. Goedgevestigde eenmanspraktyk. Totale Bruto Ontvangste: 1952 ± £2,300, 1953 ± £2,430. Prys vir klandisiwaarde £750 en vir medisyne, meubels en instrumente £250.

#### FOR IMMEDIATE SALE

Country practice about 40 miles from Port Elizabeth. Details on application.

#### ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS/LOCUMS REQUIRED

(1524) Karoo hospitaaldorp. Assistent so gou moontlik. Salaris vir die eerste 3 maande £75 p.m. (word hersien daarna) plus vry losies en kartolaag.

(1563) Transkei village. Assistant from mid-February. Definite view to partnership. Mainly native but some European work. Car not essential. Terms to be arranged.

#### OPTHALMIC INSTRUMENTS FOR SALE

(1222) Full list on application. (Quote also 1325.)

\* \* \*

#### DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

#### PRAKTYKE TE KOOP : PRACTICES FOR SALE

(PD23) Natal. Prescribing practice particularly suitable for a woman doctor interested in obstetrics and gynaecology. Total gross receipts for 1950, £1,570; 1951, £1,595; 1952 (6 months), £1,340; 1953 (3 months), £382. Premium £1,250, includes furniture, fittings, instruments, drugs and existing book debts.

(PD24) Natal South Coast. Practice suitable for doctor who does not want full-time work. £250 for drugs, dressings, instruments, etc. No charge for goodwill. Small house on  $\frac{1}{2}$  morgen, £1,600. Immediate occupation.

#### LOCUMS REQUIRED

(72) Durban. Locum required for January and February with view to assistantship. General practice. Salary to be discussed with the Principal.

(73) Near Durban. Locum for January and February. £2 12s. 6d. per day, all found. Must have own car.

(74) Zululand. Locum for February. £2 12s. 6d. per day, all found. Own car necessary.

(75) Durban. 1 January. Locum view to assistantship/partnership. General practice. Salary to be discussed.

## JOHANNESBURG

Medical House, 5 Easelen Street, Telephone 44-9134-5, 44-0817  
Mediese Huis, Esselenstraat 5, Telephone 44-9134-5, 44-0817

## PARTNERSHIP FOR SALE

(P/030) Johannesburg. Due to the retirement of one of the senior partners of an extensive essentially English-speaking partnership practice, an experienced, gentle doctor is offered the opportunity of joining this outstanding practice.

## ROOMS TO LET

Consulting room and waiting room and receptionist's services to share with medical man. Medical block, centre city.  
Rooms to share with general practitioner in northern suburbs.

## PRAKTYKE TE KOOP : PRACTICES FOR SALE

(Pr/S93) Noord-Transvaal. Goedgevestigde praktyk—geen opposisie. Gerieflike huis en spreekkamers geleë op 10 morg goeie grond. Sterk water, volop vrugtebome. D.G. aanstelling teen £425 p.j. Ongeveer 2,000 blankes in hierdie gebied. Jaarlike inkomste oorskry £2,500 en onkoste is baie laag. Premie van £4,000 sluit in eiendom, meubels, instrumente, medisynevoorraad, parafien koekkas en 1947 Studebaker sedan. Uiters billike terme kan gereel word. Hierdie winsgewende Bosveldpraktyk bied baie geleenheid vir uitbreiding.

(Pr/S104) Johannesburg. Well-established prescribing practice, in excellent position. Monthly cash receipts average £250. Three months introduction will be given. Premium required is £1,900 and includes surgery equipment, furniture and instruments and a diathermy machine. No night calls. An Afrikaans-speaking doctor will do well in this practice.

## INSTRUMENTS FOR SALE

(I/059) Goldmann (Haag-Streit) Perimeter, condition as new. £250 o.n.o.

(I/060) Siemens Heliosphere X-ray. Very little used. Perfect condition. £300 o.n.o.

(I/061) Book on psychiatry. Lists on application.

(I/062) Portable electrocardiograph, with unipolar attachment, battery operated. Excellent condition. £150.

## REQUIRED

Partnership or locum or assistantship, both with view to partnership, required in Johannesburg, by doctor with own car and a surgery in the Northern suburbs.

## Belangrike Kennisgewing

Geneeshere wat voornemens is om aansoek te doen om enige betrekking in hierdie kennisgewing genoem, en waarvoor daar 'n advertensie in hierdie uitgawe van die Tydskrif verskyn, word aangeraai om eers met die Eresekretaris van die betrekke Tak van die Mediese Vereniging van Suid-Afrika in verbinding te tree:

Betrekkings: S.A.S. & H. Siekefonds, Gesalarieerde Marketisseur.

Tak: O.V.S. en Basoetoland, Posbus 834, Bloemfontein.

## LOCUM WANTED

Locum to commence duties as soon as possible for a period of about four months in partnership practice of five in Barberton. Salary £80 p.m. and transport allowance.

Apply: Secretary, De Kaap Chambers, Pilgrim Street, Barberton.

## Provincial Administration of the Cape of Good Hope HOSPITALS DEPARTMENT

## HOSPITAL BOARD SERVICES : VACANCY

Institution	Post	Emoluments	Date	Closing Applications must be addressed to
Somerset Hospital, Green Point	Medical Practitioner Grade A.	£500-600-660- 720 p.a.	5.3.54	The Medical Superintendent, Somerset Hospital, Green Point.
	(Resident Anaesthetist)			

2. The conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. In addition to the scale of salary indicated a cost-of-living allowance at rates prescribed from time to time by the Administrator is payable to whole-time officials and employees.

4. The successful candidate, if not already in the Hospital Board Service, will be required to submit satisfactory birth and health certificates.

5. Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

6. Candidates must state the earliest date on which they can assume duty.

(A541943)

## Provinsiale Administrasie van die Kaap die Goeie Hoop HOSPITAALDEPARTEMENT

## HOSPITAALRAADSDIENS : VAKATURE

1. Aansoeke word ingewag om die volgende vakante pos:

Inrigting	Pos	Emolumente	Sluitings- datum	Aansoeke moet gerig word aan
Somerset-hospitaal	Geneesheer, Graad A.	£500-600-660- 720 p.j.	5.3.54	Die Mediese Superintendent, Somersethospitaal, Groenpunt.
Groenpunt (Binnemuurse Narkotiese-dienste).				

2. Die diensvoorraarde word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

3. Benewens die salarisssaal soos aangedui is 'n lewenskoste-toefae betaalbaar aan volydse beambtes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

4. Die geslaagde kandidaat, indien nie reeds in die Hospitaalraadsdiens nie, moet bevredigende geboorte- en gesondheidssertifikate indien.

5. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrybaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinse.

6. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

(A541943)

## FOR SALE

Specialist physician in Coastal town wishes to sell practice and equipment together or separately. Good prospects. For further particulars apply to 'A.U.M.', P.O. Box 643, Cape Town.

## Mount Frere-Dorpsbestuur

### KENNIS

Aansoeke word gevra om die betrekking deeltydse Mediese Gesondheidsebeampte. Vergoeding £12 12s. per jaar.

Besonderhede aangaande kontrak op sig gedurende kantoorre by kantoor van Dorpsbestuur-raad.

R. HOBSON  
Sekretaris

Mount Frere  
22 January 1954

## Village Management Board of Mount Frere

### NOTICE

Applications invited for post of part-time Medical Officer of Health. Honorarium £12 12s. per annum.

Details of contract available at office of V.M. Board during office hours.

R. HOBSON  
Secretary

Mount Frere  
22 January 1954

## The South African Institute for Medical Research

Applications are invited from registered medical practitioners for appointment to the post of Junior Research Fellow in the Pneumoconiosis Unit of the South African Institute for Medical Research. Previous experience in general pathology or in clinical medicine with particular reference to pulmonary disease will be a recommendation but is not essential. Under the direction of the pathologist-in-charge the Fellow will follow a research program but in addition he will have certain routine duties in the Unit.

The appointment will be for a period of one year but, subject to the approval of the Director, may be extended.

Remuneration will be at the rate of £700 per annum plus variable cost of living allowance which, at present, is £260 per annum.

The post is open to present members of the Institute Staff.

Applications must be received within 21 days of the appearance of this advertisement.

Further particulars can be obtained upon application to the Director, S.A.I.M.R., P.O. Box 1038, Johannesburg.

## Kromboom Nursing Home

Attention—Kromboom Nursing Home under new management. Expert and kindly attention given to all Medical, Surgical and convalescent patients. Inspection invited. Telephone matron 6-6627, Cape Town.

## O.F.S. Provincial Administration VOORTREKKER HOSPITAL KROONSTAD

### VACANCY: SPECIALIST ANAESTHETIST

Applications are invited from registered specialist anaesthetists for the above post, in a part-time capacity, with right of private practice.

Duties consist of 4 sessions of 4 hours each, per week, at remuneration of £205 p.a. per session.

Applications on prescribed form No. Z83, obtainable from the Secretary, or any Magistrate's Office together with certified copies of Certificates, testimonials, Birth certificate, and Health Certificate, will be received by the undersigned.

F. A. VAN COLLER  
Medical Superintendent

Kroonstad  
21 January 1954

## Transvaalse Proviniale Administrasie

### VAKATURES BY PUBLIEKE HOSPITALE

Aansoeke word ingewag van kandidate met geskikte kwalifikasies vir die onderstaande poste by Publieke Hospitale in die Transvaal.

Aansoeke moet gerig word aan die Geneeskundige Superintendent of Verantwoordelike Geneesheer van die betrokke hospitaal en moet volle besonderhede bevat aangaande die ouderdom, professionele, akademiese en taalkwalifikasies, ondervinding en huwelikstaat van die applikant en moet voorts 'n aanduiding bevat van die vroege datum waarop diens aanvaar kan word. Afskrifte van onlange getuigskrifte moet aangeheg word by aansoeke.

Lewenskostetoeleae tans betaalbaar aan voltydse werknemers:—

Hospitaal	Pos	Emolumente	Opmerkings
Pretoria	Junior Geneesheer (1)	£1200 x 50- 1500	Geregistreerde mediese praktisyn. Hoér kwalifikasies in medisyne 'n aanbeveling.
Germiston	Ongevalle-beampte (1)	£620-780- 820-860	Geregistreerde mediese praktisyn. Moet vir ten minste twee jaar ge-kwalifiseerd wees.
Johannesburg	Mediese Registrateur (1)	£620-780- 820-860	Geregistreerde mediese praktisyn.
Pretoria	Kliniese Assistant (Departement van Interne Genes-kunde (1)	£620-780- 820-860	do.

(44314)

## O.V.S. Proviniale Administrasie

### VOORTREKKER-HOSPITAAL KROONSTAD

### VAKATURE: SPESIALIS ANAESTETIKUS

Aansoeke word gevra van geregistreerde spesialis Anaestetikusse vir bovenoemde pos, in 'n deeltydse hoedanigheid met die reg van private praktyk. Dienste bestaan uit 4 sessies van 4 uur elk per week, teen besoldiging van £205 per jaar per sessie.

Aansoeke op die voorgeskrewe vorm Z83, verkrybaar van die Sekretaris of enige Magistraatskantoor, tesame met Gesondheids- en Geboortesertifikate, sowel as gesertifiseerde afskrifte van sertifikate en getuigskrifte, sal deur ondergetekende ontvang word.

F. A. VAN COLLER  
Geneesheer Direkteur

Kroonstad  
21 Januarie 1954

## Siekefonds van die Suid-Afrikaanse Spoorweë en Hawens

### AANSTELLING VAN NARKOTISEUR : BLOEMFONTEIN

Aansoek word van geregistreerde spesialiste ingewag vir aanstelling in die betrekking van Narkotiseur, Bloemfontein, teen 'n salaris van £1,392 per jaar, plus die gelei en toelaes wat in die regulasies van die Siekefonds voorgeskryf word en met die reg om privaat te praktiseer.

Die salaris is onderhewig aan wysiging in ooreenstemming met die sensus van lede wat op 1 April van elke jaar afgemeen moet word.

Die aanstelling geskied kragtens die regulasies van die Siekefonds, en opseggings van dienste is onderworpe aan vier maande kennisgewing deur een van beide partye.

Die suksesvolle applikant moet te Bloemfontein woon, diens aanvaar op 'n datum wat gereel sal word, en sy pligte ooreenkomsdig die regulasies van die Siekefonds uitvoer.

Aansoek moet die Distriksekretaris, Distriksiekefondsaad, Oranje-Vrystaat, Charlesstraat 2, Bloemfontein, nie later as 20 Maart 1954 bereik nie, en applikant moet die volgende vermeld:

1. Volle naam.
2. Kwalifikasies (waar en wanneer verkry.)
3. Ondervinding (waar en wanneer verkry en opgedoen).
4. Datum van geboorte.
5. Land van geboorte.
6. Getroud of ongetroud.
7. Of ten volle tweetalig.
8. Of Suid-Afrikaanse burger.
9. Watter staatsbetrekking beklee word, indien enige.

Werving deur of ten behoeve van enige applikant stel so 'n applikant bloot aan diskwalifikasie.

Enige verder besonderhede wat verlang word, kan op aanvraag van die Distriksekretaris by die bovermelde adres verkry word.

P. J. KLEM  
Hoofsekretaris

Johannesburg  
20 Maart 1954

## Provincial Administration of the Cape of Good Hope

### HOSPITALS DEPARTMENT: VACANCY Victoria Hospital, Wynberg MEDICAL PRACTITIONER, GRADE B

Applications are invited from suitably qualified candidates for appointment to the post of Medical Practitioner, Grade B at the abovementioned institution with salary on the scale £720 x 40—960 per annum.

In addition, a temporary cost of living allowance at rates prescribed from time to time by the Administrator, is payable. The present rates are £320 per annum for a married person and £100 per annum for a single person.

The appointment of the successful candidate will be in terms of and subject to the provisions of the Hospital Board Service Ordinance No. 19 of 1941 and the regulations framed thereunder.

Applications should be submitted (in duplicate) on the prescribed form Staff 23 which is obtainable from the Director of Hospital Services, P.O. Box 2060, 112, Loop Street, Cape Town, The Medical Superintendent, Wynberg. Orthopaedic and Convalescent Hospitals, P.O. Box 1487, 58 Loop Street, Cape Town, the Medical Superintendent of any provincial hospital or the Secretary of any School Board in the Cape Province.

Applications should be addressed to the Medical Superintendent, Wynberg, Orthopaedic and Convalescent Hospitals, P.O. Box 1487, 58 Loop Street, Cape Town, and should be posted to arrive not later than noon on 12 March 1954. (A560629)

### ASSISTANT REQUIRED

Assistant with view to partnership required for Umtali, Southern Rhodesia. Mixed General practice. Commencing salary £100 per month. To start as soon as possible. Apply to 'A.U.F.', P.O. Box 643, Cape Town.

### MEDICAL OFFICER

The Alpha Harris Benefit Society requires Medical Officer for the Municipal area of Germiston.

Please reply with full particulars to the Secretary, P.O. Box 24, Knights.

(This appointment has the approval of the Medical Association of South Africa—Associate Secretary, M.A.S.A.)

### PLAASVERVANGER BENODIG

Plaasvervanger te Indwe vanaf laaste week in Junie of 1 Julie vir ses weke. Te werk saam met een venoot terwyl ander op vakansie is. £2 12s. 6d. per dag. Kar nie noodsaaklik. Vry losies en inwonings. Skryf aan 'A.U.G.', Postbus 643, Kaapstad.

### ASSISTANTSHIP OR LOCUM WANTED

Assistantship or locum wanted with view to partnership. Required in Peninsula by doctor with car. Hospital and general experience. Write to 'A.U.J.', P.O. Box 643, Cape Town.

### LOCUM REQUIRED

Gobabis, S.W.A. Locum required for three months commencing 15 April 1954. For further particulars please write to P.O. Box 102, Gobabis, S.W.A.

### LOCUM REQUIRED : LICHTENBURG

Locum required from 10 May to 31 July. General Practice. Own car necessary. Petrol and oil supplied. £3 3s. per day all found. Write to 'A.U.K.', P.O. Box 643, Cape Town.

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### THE "OXYCILLIN" ATOMISER

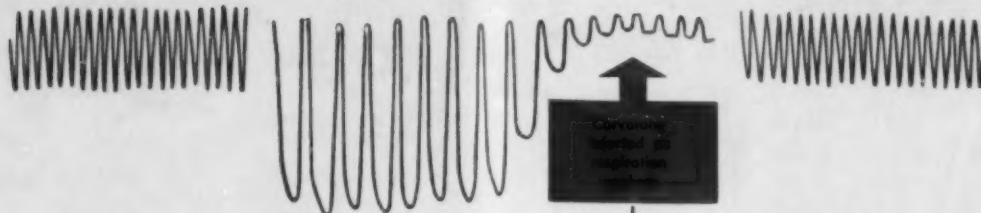
THE "OXYCILLIN" ATOMISER ADMINISTERS OXYGEN AND PENICILLIN IN AEROSOL FORM. IT IS SPECIALLY DESIGNED FOR USE WITH OXYGEN TENTS OR ATTACHMENT TO AN OXYGEN INHALER. IT ADMINISTERS A DRY VAPOUR IN A FINE STATE OF SUBDIVISION AND EXTENSIVE RESEARCH HAS PROVEN THAT THE "OXYCILLIN" FULFILS ALL THE REQUIREMENTS FOR EFFECTIVELY PRODUCING PENICILLIN AEROSOL IN A STATE READILY ABSORBABLE.

THE UNIT IS ATTACHED TO A TWO-STAGE OXYGEN REGULATOR AND A CONTROL KNOB ENABLES THE SOLUTION TO BE GIVEN FOR SPECIFIC PERIODS WHILST OXYGEN IS GIVEN CONTINUOUSLY. A FINELY CALIBRATED SOLUTION CONTAINER ENSURES ACCURATE DOSAGE.

Enquiries:

53 Third Street, Bezuidenhout Valley, Telephone: 24-6936, Johannesburg

Normal respiration . . . . . slowed, deepened and finally depressed by urethane . . . . . restored to normal by an injection of CORVOTONE.



**Safe**

**and**

**efficient**

**cardio-respiratory**

**stimulation**

CORVOTONE is a potent analeptic having the advantage of a wide margin of safety. It is an invaluable aid in the emergency treatment of cardio-respiratory failure.

CORVOTONE is given by subcutaneous, intramuscular or intravenous injection, according to the urgency of the case.

CORVOTONE-ORAL is useful in chronic and mild conditions when immediate action is not essential.

2 ml. ampoules. Boxes of 6, 50 or 100. Bottles of  $\frac{1}{2}$  fl. oz. (14.2 ml.) or 100 ml.

→ **CORVOTONE**  
NIKETHAMIDE B.P.

Manufactured by Boots Pure Drug Co. Ltd., Nottingham, England



P.O. Box 1559, CAPE TOWN

Obtainable through  
B.P.D. (SOUTH AFRICA) (PTY.) LIMITED.

P.O. Box 45, JEPPESTOWN, TRANSVAAL